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Page 14

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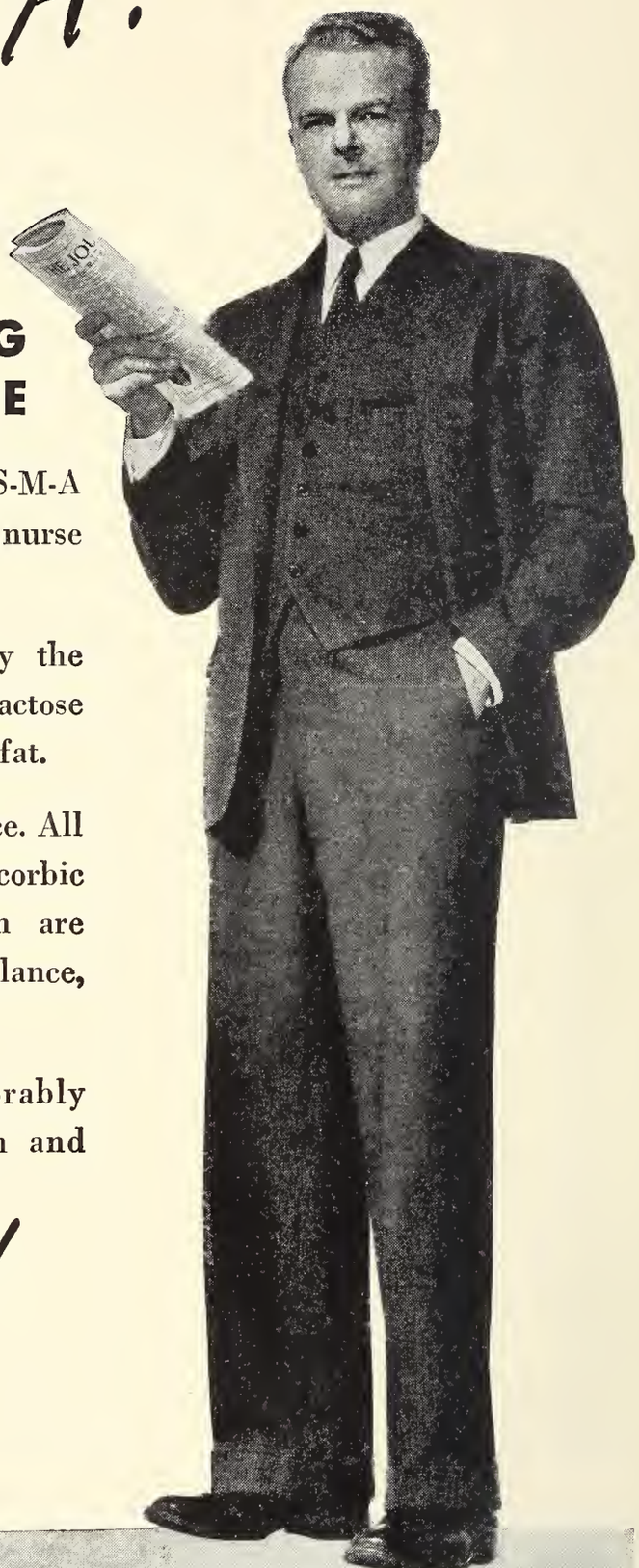

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*The Treatment of Burns**

By Harry Brinkman, M. D., Farmington, Maine

The treatment of burns is an ever-recurring subject, particularly since the present war is producing such a large number of burns.

It is probably axiomatic that the treatment of those diseases and lesions which have the longest lists of medications for their treatment are the most unsatisfactorily treated. Harkins[1] in a recent article and in his book lists 75 different methods and applications for the local treatment of burns. This will indicate that no one method has found universal acceptance. It is beyond the scope of this paper to attempt to consider the value of these various and sundry applications in the local treatment of burns. The choice of any one or combination of methods must lie with the individual who treats the specific case. The extent, depth, type of burn, location and region involved will determine the procedures to be followed. All one can hope to do is to focus our attention on certain principles which will apply more or less to all. To list in detail the various procedures that might be undertaken for the various types of burn would be futile, but the focusing of our attention on some basic physiological and surgical principles may be helpful.

In our constant and ardent search for some simple application which can be applied to a burned surface, as a magic salve, which will produce healing, we oftentimes forget or ignore some of the most important factors involved, not only factors in the process of healing and reparation, but of some of the more immediate effects of the burn, such as shock and infection. The saving of life is the primary consideration, not the ease and simplicity of treatment. Any adequate therapy of burns must recognize the damage that is done and the dangers to which the body is exposed once a severe burn occurs. The problem of treatment is three-fold: 1—the saving of life; 2—local treatment for healing; 3—the restoration of function.

Burns have for long been divided into three groups: The first degree burn being merely an erythema without actual tissue destruction. A second degree burn is one in which there is destruction of the epidermis with or without vesicle formation. A third degree burn is one involving complete destruction of the skin with or without destruction of the underlying tissues. The treatment of a first degree burn requires treatment of the patient and not of the burn; the tissues will live if the patient survives. If it is ex-

* Read before the meeting of the Maine Medical Association at Poland Spring, Maine, June 22, 1942.

tensive it may well produce shock which may require active treatment.

Shock is to be anticipated in any burn that is at all extensive and the extent that is required to produce shock is extremely variable. One may find a patient with a burn which at first appears not to be serious and yet the patient may be in primary shock. How much a part pain, fright, and extreme over-exertion in trying to escape may play cannot be stated but they may well be important. Many observers feel that they are, and it is the consensus that morphine here in adequate dosage is desirable.

Secondary shock is to be anticipated in all severe burns, and measures for its prevention and treatment take precedence. Whether or not this shock is due to a specific tissue toxin producing a so-called burn toxemia has not been clearly demonstrated. It may well be and probably is an important element. A tremendous amount of work has been done in this field and the majority of observers probably feel that such a toxin is present. However, it probably will not be gainsaid that the loss of body fluids by weeping externally and also by the "internal bleeding" into the tissues adjacent to the burn are very important factors in producing a shift of body fluids, hemoconcentration, circulatory insufficiency, and anoxia. The prevention of this circulatory failure and anoxia, which if allowed to persist will result in irreparable tissue damage, is the important first consideration in the treatment of any patient with extensive burns. The problem is two-fold: the replacement of fluid already lost when the patient is first treated, and the prevention of further loss by adequate treatment of the burned areas. The shift in body fluids resulting from a burn is not due to a loss of blood but to a loss of serum or a "plasma-like" fluid. Thus transfusion of whole blood is not only not necessary, but less desirable than the transfusion of plasma in adequate amounts. It is not sufficient to give the patient simply a transfusion of plasma, which with present arrangements is a very simple thing to do; it must be given in amounts according to individual needs. The quantitative determinations of the plasma needs is just as important as that of any other type of medication. Harkins puts it well when he says, "There is no more excuse for always giving a shocked patient a pint of plasma than for always giving a diabetic patient 10 units of Insulin."

Harkins mentions five different methods and formulæ for determining plasma requirements for patients in his recent article. The results of these various methods correspond very closely in their determinations for the individual patient. Where laboratory facilities are limited Berkow's formula may easily be used—50 cc. of plasma is given for every estimated percent of body surface affected by a second or third degree burn. Thus, an individual with a burn involving 25% of the body surface should have about 1,250 cc. of plasma. This should be given within the first 12 hours. Harkins' own formula is based upon the hematocrit reading — 100 cc. of plasma being given for every point the hematocrit reading exceeds the normal of 45. If the plasma protein content of the patient's blood is low, additional plasma must be given to compensate. Children are given amounts according to body weight.

Although the administration of blood plasma forms the basis for the treatment of burn shock, other routine measures must not be neglected. Most observers feel that oxygen should be given artificially because of the dangers of anoxia. Elevation of the foot of the bed, absolute rest, and artificial heat obviously should be given. The value of adrenal cortex in combating shock is still not clear.

After primary shock has been overcome and the patient's general status evaluated and the dangers of shock considered, one can then focus his attention upon the treatment of the burned areas. In recent years the treatment of fresh wounds has progressed remarkably. Formerly, the iodine bottle or other antiseptic was constantly kept in readiness and the contents poured into the wound. This was expected to sterilize the wound and normal healing was expected to take place with the use of some ointment. Such, we now know, is not the case. We have come to learn the value of cleansing and debridement; that a contaminated wound can be made surgically clean, and that a wholesome respect for living tissue pays dividends in kindly healing. Nursing, not cursing, here also is the watchword. Why

then should we not look upon a fresh burn, even though a specific toxin may be present, as a large open wound and apply similar treatment? In our search for some medication that will sterilize and heal we are so inclined to forget the principle that has been dinned into our ears, that a clean wound will heal if it is kept clean and at rest. This has been emphasized over and over again by recent writers, particularly Mason,[2] Allen and Koch,[3] and others. Allen and Koch in their recent article have presented this phase in an admirable fashion. As great care should be exercised and meticulous surgical technique used in cleaning a burned area as in performing a laparotomy or debriding a compound fracture. A large raw surface, if still fresh, can be made surgically clean if enough care and patience is used. Because of the danger of impending shock and anoxia, and because of the time required, these workers advocate avoiding a general anesthetic if possible by using morphine in adequate dosage. They have found it unnecessary to use any other analgesics or anesthesia. The room should be warm and the irrigating fluids warmed to body heat.

The surgeon and assistants should be scrubbed and should wear sterile gowns and gloves, and have the mouth and nose masked. This is important and is done after preliminary cleansing of the surrounding areas and the patient is placed on a sterile sheet. Very carefully all devitalized tissue is removed and washed away, all blisters are opened and the dead skin excised. Grease and oils may have to be removed with some fat solvent and should be done thoroughly. The whole area then is washed with plain soap and water, and finally thoroughly rinsed and washed with sterile water or saline to insure as complete mechanical cleansing as possible. As soon as the areas are cleaned they must be covered as soon as possible to prevent contamination, particularly contamination from the noses and throats of those working with the patient. This is a very dangerous source of infection.

What type of dressing should be applied? Davidson[4] has demonstrated that such a surface can be closed safely by tanning and thereby has advanced the treatment of burns and has lowered the mortality rate of burns considerably. Davidson used tannic acid originally and it is still used, but since his work other coagulants and escharotics have been advocated with a view to producing an eschar more rapidly and one that is more pliable. Many of these have worked well. However, in dealing with a lesion which involves primarily the destruction of tissue it would seem that the use of a medication that produces further destruction of tissue would be undesirable provided the same purposes can be accomplished by milder methods. The purpose of the eschar and dressing is to prevent further loss of body fluids and to prevent the entrance of infection from without. Such a dressing has been advocated by Allen and Koch and it seems to have definite advantages over the so-called tanning agents.

When a burn is first seen it is difficult to determine the depth of tissue destruction. In many burns it is conceivable that many small islands of viable skin structure may remain, which can easily be made non-viable by the application of an escharotic, which might well be saved by using a non-irritating and non-coagulating dressing. Healing can only occur from epithelial elements which remain or by ingrowth from the periphery, and the saving of all these skin structures is important in future healing. These writers advocate the application of a fine mesh gauze which has been impregnated with petrolatum over which a thick sterile compression dressing is applied. Compression is obtained either by the use of a stockinette or elastic circular bandage. This type of dressing it seems has all of the valuable features of the tanning method without the objection of destroying more tissue which might be valuable in tissue regeneration. This dressing then has the following advantages:

1. It is non-adherent; it can easily be removed if necessary.
2. It does not destroy tissue, it is non-irritating.
3. It is comfortable and supporting.
4. The pressure controls the loss of tissue fluids externally and prevents much of the internal "bleeding."
5. It eliminates dead spaces.

Continued on page 16

*The Freudian Theories**

Section II: Historical

By Israel Newman, M. D., Augusta, Maine

Freud sees the human psychological development as analogous to the human physical development. There is first the ovum, then the cell-mass, then the differentiation of the cell-mass into the various tissues. Analogous to the ovum is the libido, out of which the various strivings and interests develop. In the process of its development and differentiation, the libido passes through such stages as the psyche of the entire race has gone through. Freud says: "To all appearances the child, in the development of his soul simply recapitulates the evolution of the specie analogous to the recapitulation of his physical development which has long since been accepted by embryology."[1] The libido passes through a stage which harks back to an age when incest was frequent. The jealous father would punish the offender by mutilating his sex organs. Fear of this punishment checked the impulse. The mind passes through the corresponding embryonic stage of incest wishes and fear of the appropriate punishment. These wishes and fears do not manifest themselves in consciousness; they remain in the unconscious; but they none the less influence conscious mentation and conscious tendencies. "We have conjectured," says Freud, "that in the early days of human family castration really was performed on the growing boy by the jealous father and that circumcision which is so frequently an element of puberty rites is an easily recognizable trace of it."[2]

Between the ages of two and five the boy child indulges in unconscious phantasies of incest with his mother and of killing his father who is his rival. The constellation of ideas about this incest wish Freud terms the Oedipus Complex. These fantasies give rise in the unconscious to a sense of guilt and to fear of the appropriate punishment—deprivation or mutilation of the sex organs. This fear constitutes the Castration Complex. These two complexes constitute the vital centers of the psychoanalytical theories.

In the boy the castration complex develops after the Oedipus complex; in the girl the history is reversed. The girl is at first attached to her mother (pre-oedipal stage). During this stage she has unconscious desires "to have a child by her mother."[2] "The attachment to the mother soons ends in hate."[2] "The first complaint against the mother . . . is that she has given the child too little milk . . . The next accusation flares up when the next child is born . . . Another source of the child's antagonism against the mother . . . when the mother forbids pleasurable activities . . . The girl holds her mother responsible for her" not being a boy.[2] "The wish with which the girl turns to her mother is the wish"[2] to be a boy. This wish is ultimately "replaced by the wish for a child."[2] Thus the girl enters the "situation of the Oedipus complex." "Her mother becomes her rival." "The girl remains in Oedipus situation for an indefinite period, and only abandons it late in life, and then incompletely."[2] Thus in the girl the "castration complex prepares the way for the Oedipus complex."[2]

The Freudian theories had their beginning in the interpretation of a case of hysteria at which Freud worked with Breuer. Among others was the case of a girl who, while watching in painful anxiety at the bedside of her father, fell in a twilight state and experienced a frightful hallucination as the result of which her right arm "went to sleep" as it hung over the sofa. From this developed an anesthesia and a contracture of that extremity. She also became voiceless with fear. She attempted to pray, but words did not come to her. She finally managed to utter a child's prayer in English (her native language was German). For a year and a half thereafter

* Continued from the December, 1942, issue of the Journal, Page 275

she could not understand her mother tongue. Among other symptoms was her inability to drink. When she was put in a hypnotic state she recalled, among other things, her disgust at seeing her governess' dog drinking out of a glass left on the floor. She also related her becoming voiceless with fear when she imagined seeing a snake. With the recollections of these and other incidents her symptoms disappeared. "It turned out that all her symptoms went back to the moving events which she had experienced while nursing her father; that is to say her symptoms had a meaning . . . There had been some thought or impulse which she had to suppress while she was at her father's bedside, and in place of it, as a substitute for it, the symptoms had afterwards appeared. But as a rule the symptom was not a precipitate of a single such traumatic scene but was the result of a summation of a number of similar situations. When the patient recalled a situation of this kind in a hallucinatory way under hypnosis and carried through to its conclusion, with a free expression of emotion, the mental act which she originally suppressed the symptom was wiped away and did not return. Breuer succeeded after long and painful efforts in relieving the patient of all her symptoms."[1] The inference was that the formation of the symptoms was due to the damming up of an affect and its corresponding affective expression, and that the treatment provided an outlet for the maintenance of the symptoms—directed to be discharged along normal channels. This mode of treatment was termed Catharsis or Abreaction. Breuer believed that "the processes which could not find normal outcome were such as originated during unusual, hypnoid, mental states."[1]

Breuer and Freud found that occasionally the symptoms harked back to incidents of childhood. But while Breuer believed all the above modes of formation of symptoms to be true in hysteria only, Freud assumed that the same agencies were at work in other psychoneuroses also; assumed that all were due to repressed repellent urges which remained in the unconscious, not as static potentialities (as conditioned reflex arcs), but as dynamic elements producing dreams, symptomatic acts, symptoms, etc.

While Breuer claimed that in the above case, as well as in others, there were no sex elements behind the symptoms, Freud insisted that sex elements were present in all cases. "I now learned," writes Freud, "that it is not *any* kind of emotional excitation that was behind the phenomena of the neuroses, but regularly one of a sexual nature, whether it was current sexual conflict or the affect of earlier sexual experiences."[1]

Freud concluded that hysteria was not a case of splitting of consciousness, as Janet believed, but that it was the result of the ability to convert repellent urges into symptoms. Not finding such urges in the recent experiences of his patients, Freud learned to look for them in the remote past as far back as babyhood; and since such phantasies could not be demonstrated in babes, Freud assumed that they were taking place, without the babe's knowledge, in the unconscious which, according to his theories, is harking back to an imaginary age where such events were parts of daily life. Finding that not all patients could be hypnotized and that statements made by the hypnotized were not always reliable, Freud resorted to a new method of arriving at those buried complexes, a method consisting of instructing the patient to tell, without any reservation all that is occurring to his mind.

As to the aim of this form of treatment Freud says that "it is no longer to abreact but to uncover repressions and replace them by facts of judgment which might result either in the acceptance or in the rejection of what had formerly been repudiated. I showed my recognition of the new situation by no longer calling my method of investigation and treatment *catharsis* but *psychoanalysis.*"[1]

The occurrence of the war neuroses threatened to upset the bases of the Freudian theories. Here were neuroses unmistakably due to the conditions at the front and not to sex complexes. But these were Freud's comments on that issue: "the war neuroses, they said, proved that sexual factors were unnecessary to the etiology of neurotic disorders. But their triumph was frivolous and premature. For on one hand no one had been able to carry out a thorough analysis on a case of war neurosis, nothing whatever was known

for certain as to their motivations . . . On the other hand psychoanalysis had long before arrived at the concept of narcism and of narcistic neuroses, in which the libido is attached to his own ego instead of an object."[1]

Thus we find the concept of libido extended to include also self preservation tendencies.

In his therapeutic efforts to bring to light those buried complexes which are behind the neuroses, the analyst almost always encounters those forces which had originally brought about the repression of those urges; in other words, he encounters what he terms Resistance. If the patient "overcomes his reticence the resistance will find another means of expression. It will so arrange it that the repressed material itself will never occur to the patient but only something which approximates it in an allusive way . . . The analyst who listens composedly, but without any constrained effort, to the stream of the associations, and who from experience has a general notion of what to expect, can make use of the material brought to light by the patient according to two possibilities. If the resistance is slight, he will be able from the patient's allusions to infer the unconscious material itself; if the resistance is stronger he will be able to recognize from the association as this becomes more remote, the character of resistance itself, and will explain it to the patient. Uncovering resistance, however, is the first step towards overcoming it. Thus the work of psychoanalysis involves the art of *interpretation.*"[1]

Section III: Criticism

It is to be noted that the psychoanalytical theories avoid any mention of the possible modification of the brain cells as factors in the psychoses and psychoneuroses. Thus far no histological changes in these cells have been found in such cases. We do not even know what the activities of these cells are in conscious mentation.

Hypotheses about the unknown are interesting and useful. But in order to convince, they must be logical and consistent. This cannot be said of the Freudian theories.

That neurological activities go on in the body without giving rise to consciousness, is certain. But each activity of this sort is, beyond doubt, *preceded* by a stimulus, by something that gives rise to it. If so how can we imagine the Id or the subconscious ego—unconscious neurone-mechanisms—reacting to a stimulus which has not yet taken place: putting on a mask so as to fool the censor who, discerning the wish in its nudity, may, *in the future,* forbid its entrance into consciousness?

Assume that the neurone mechanism, of the id, for example, is capable of constructing the possible results of its nudity in its unconscious imagination, *prior* to the masking process: in other words, assume that the id is a personality: then the question arises, what is his relation to the ego? Does it co-experience the pains and pleasures of the latter? If so, why inflict on it a deafness, a blindness, a contracture or a distressing attack of asthma? According to Freud, this constitutes the revenge of the id on the ego, a case of one's cutting one's nose off in order to spite one's face. Assume that this id is very idiotic. Assume also, as Freud does, that the id is out of contact with reality and is, therefore, unaffected and unmodified by it. "The pleasure-pain principle reigns supreme in it . . . it is unmoral, illogical; it has no unity of purpose." If so, how does it happen that it has full knowledge of the principles and predilections of the censor (or the censorship of the ego)? How is it capable of appraising in the light of this knowledge the urges in question? How does it happen to be so ingenious at the selection and elaboration of disguises which will pass the censor (and even challengee the wisdom of the psychoanalyst)? Can one speak of a personality (or part-personality) which modifies its urges to conform to the regulations of the censorship and—indirectly—to the laws of society, as having no unity of purpose, as being out of contact with the realities of the outer world?

The unconscious ego is another inconsistent member of Freud's dramatis personae. This personality also acts with foresight to consequences and in accordance with fixed poli-

cies which show superior wisdom and idocy vastly more preposterous than that of the id.

Everywhere we see the unconscious ego as a highly intelligent personality. It is well versed in the laws, customs and taboos of society. It is capable of appraising the ethical value of this or of that urge, of this or of that disguise. It fore-imagines the effect of this or that urge upon the conscious ego who must be shielded from any uncomfortable thought-content. It is an ever-faithful watchdog. In its extreme solicitude for the serenity and joy of the conscious ego, the unconscious ego never falls fully asleep during the night but keeps one eye open watching what is going on in the camp of the id who is very much awake—in fact, too much awake—even in the small hours of the night when it expects to catch the unconscious ego napping. But, to the id's disappointment, the unconscious ego is alert. It lets dreams come and go as they please, since they lessen the chances that the conscious ego's sleep be broken up by outside noises, etc.; sees to it that the dreams be wish-fulfilling — good-wish-fulfilling only. But when a bad-wish-fulfilling dream is about to get in, and there is the danger that the conscious ego will suffer from shame over the fulfillment of a bad wish and perhaps break up his sleep, the unconscious ego comes to the rescue and treats the conscious ego to a horrifying nightmare which wakes it up and *spares* its feelings!

An accidental mistake? No! It is a fixed policy which is always carried out.

But a nightmare is, after all, but a brief, passing incident. The ingenuity and solicitude of his guardian become clearly evident now and then in wakeful life. When the intrusion of a bad urge cannot be obviated, the unconscious ego, fore-imagining the possible displeasure thereof to the conscious ego, comes to the rescue by inflicting upon it a compulsion neurosis of which "few or none are cured"—an obsession which keeps the consciousness so busy that the bad wish may have no opportunity to enter. The remedy may consist of an uncontrollable compulsion to set fire to buildings, to jump to death out of high windows, to run in front of speeding cars or to indulge in the most nauseating activities possible. It may—if clinical records are reliable—impell the mother to cut the throats of her children. All these in order to save the conscious ego from the embarrassing thought of illicit relations with a parent who may happen to have died ten, twenty or thirty years ago!

You may conclude that for all its ethical education the unconscious ego is an imbecile. But Freud will convince you to the contrary. According to Freud, when a bad urge threatens to invade, and the unconscious ego judges that it is too weak to suppress it, it "calls to aid a technique which at bottom is identical with that of normal thinking. Thinking is an experimental dealing with small quantities of energy, just as a general moves miniature figures about the map before setting his troops in action. In this way the ego anticipates the satisfaction of the questionable impulse."[2] This anticipatory satisfaction awakens the memory of castration that the ancestors experienced—how many thousands of years ago? This memory awakens in the conscious ego an anxiety (an anxiety neurosis) which may last months or years, but which serves as a warning and prevents the admission of the bad urge. One who is well versed in social ethics and who, general like, experiments with small quantities of energy and, accordingly, succeeds in carrying out his plans cannot, by any standard, be considered an imbecile.

With these two personalities, the id and the unconscious ego, as the principal managers of our life, is it not a wonder that life has some sense and coherence and that we somehow muddle it through?

But it is no wonder at all that our daily life, as Freud sees it, is intimately interwoven with insanity. Freud wrote a book on "Psychopathology of Everyday Life."

The insanity of our daily life is further obvious from Freud's interpretation of the war neuroses; from his seeing in these disturbances manifestations of narcism. All of us working for our daily bread and taking precautions to preserve our health are cases of narcistic neuroses, in other words, psychoses, since self-preservation is as much a motive in our lives as in this or that case of war neurosis "in which the libido is attached to his own ego instead of an object."

Imagine the bewilderment of the faithful psychoanalyst confronted by a case of war neurosis in the form of hysteria. Since it is a war neurosis, it is a narcistic neurosis, an insanity; since it is hysteria, it is a case of transference neurosis.

Should he be a still more faithful psychoanalyst, he would have to conclude that, since daily life is—because of its self-preservation tendencies—a psychosis, the only ones of the general population who are *the most sane are the hysterics,* since theirs are cases of merely psychoneurosis!

One still wonders how the psychoanalytical theory survived the "shell-shock" it received from the war neuroses. The "medicine" that the theory got for it was almost as bad as—if not worse than—its ailment. Suppose I said: "The upper half of the visible side of the moon is the continent of Gog," and later I said: "The lower half of the visible side of the moon is also the continent of Gog," and finally I said: "The entire visible side of the moon is also the continent of Gog:" would you not wonder at me? Freud's theory made analogous assertions about the libido: at first it stated that sex and a few allied elements constituted libido; later it added more, and more, and more elements; and finally it added all that was left—the tendency to self-preservation! Why state that there is on the moon a continent named Gog when the continent of Gog and the moon are identical?

Even as the cases of "shell-shock" upset the theory of the sexual bases of the neuroses so did the cases of nightmares following war experiences upset the theory that dreams are wish-fulfilling in their nature. Even Freud could not overlook the fact that "people who have had severe shocks or who have gone through severe psychic traumas (such as were frequent during the war, and are also found to lie back of traumatic hysteria) are continually put back into the traumatic situation in dreams."[2] "In my opinion," he says farther, "we ought not shrink from the admission that in such cases the function of the dream fails."[2] That post-war and post-traumatic dreams are non-sexual has been proven; that all other dreams are sexual is neither plausible nor supported by demonstrable evidence: and yet one of the fundamentals of psychoanalysis is the assumption that most other dreams are sexual in character, wish-fulfilling and having as their purpose the modification of anything which might awaken the sleeper. All other structures collapse when their underpinnings are removed. But psychoanalysis has a charmed existence: it remains erect and unperturbed even after its supports have been demolished.

According to the Freudian school "the unconscious is that vast quantity of mental life which either was never in consciousness, or, previously in consciousness, has been repressed."[3] But how can we imagine unconscious wishes? "Even though such terms as unconscious love, hate, etc., are used in psychoanalysis, they have inexact meanings."[3] According to Freud "Instincts can never find their representation even in the unconscious except through ideas that represent the instincts. And just so it is beside the mark to regard emotions, feelings, affects as unconscious: they are not in the unconscious in the same sense that idea are."[3] Accordingly, mental content can exist in either of following three "senses" or states: in a conscious sense; in an unconscious sense and in — a totally inconceivable state — a sense which is neither conscious nor unconscious!

There is no evidence for the existence in normal life of an unconscious—of processes analogous to those of reasoning which go on without giving rise to awareness. If such exist they are most likely mere fragmentary links between the conscious processes—complementary elements but not processes tending to induce contrary or unrelated responses; not, at any rate, elements which are integrated into personalities each with a nature of its own. Nor can we find any biological reasons for such sub-personalities. The conditions wherein there is the suggestion of two (or more) simultaneous foci of mentation are hypnosis and hysteria (perhaps also schizophrenia)—abnormal conditions which may be due to this multiplicity artificially induced.

"We have discovered," says Freud, "that sexual tendencies permeate life from very birth. We have also ascertained that it is to combat these urges that the infantile ego resorts to repressions."[1] The unconscious of the

infant is preoccupied with sex phantasies, with feelings of guilt and with "fear of mutilation by the father . . . on account of the unconscious incest wishes towards the mother."[3] The inference is that behind its mask of idiocy there is in the infant's mentality an intelligence that is capable, not only of experiencing guilt, but also of inferring from the behavior of those around him what the social standards are; of appraising his urges in the light of the principles underlying those standards; of referring to historical precendents (of castration) and of devising infallible psychological methods of dealing with such situations!

Inheritance of acquired characteristics is disputable, but probable, at least imaginably possible; recent experimental data point to such possibilities. But to assume the inheritance of memories of specific incidents is going too, too far — memories which through thousands of years have never been conscious! If so, how does it happen that language is not remembered? In so far as it is known, the child's ability to learn a language is the same whether his ancestors used it or not.

Furthermore, accept that there was an age when castration was practiced, and you have to explain how humanity survived. Castrated people have no children. We of today are surely descendents of those who escaped castration. And is it likely that every human being inherits a memory of what his remote ancestors never experienced, only heard of or —at most—witnessed only?

It is superfluous to point out that the two highly implausible hypotheses, the Oedipus complex and the castration complex, are the vital centers of the psychoanalytical theories —the main pillars of this super-skyscraper. While the other two pillars, the theory of wish-fulfillment of dreams and the theory of the sexual basis of neuroses and dreams, were shattered by clinical proof to the contrary, the former two remain immune to such attacks: there can be no proof that they do not exist. Could one disprove the assumption that, when there is no one to see them or hear them, two little imps are dancing on the keys of my typewriter?

The clinical evidence for the support of this or that part of the psychoanalytical theory is obtained in an intriguing manner. To illustrate the method of psychoanalytical investigation we will again quote from Freud the following statements: "The analyst who listens composedly but without any constrained effort to the stream of associations, and who from his experience *has a general notion of what to expect* (italics ours) can make use of the material brought to light by the patient according to two possibilities. If the resistance is slight, he will be able, from the patient's allusions to *infer* (italics ours) the unconscious material itself; or if the resistance is stronger he will be able to recognize from the association, as this becomes more remote, the character of the resistance itself and will explain it to the patient. Uncovering resistance, however, is the first step towards overcoming it. Thus the work of the analysts involves the art of *interpretation.*"[1] Thus the complexes *never* come to the surface; what do come are statements "that approximate them in some allusive way." But the analyst who knows in advance what he is going to find is certain to come across in the course of weeks' (or months', or years') talk a statement, a phrase or a word which he can interpret in the light of his psychoanalytical convictions.

Furthermore, the psychoanalyst is equipped with more than the mere "art of interpretation." After many years of "investigation" the theory has "discovered" many objects which are *sex symbols.* A house, for instance, is the symbol for a woman; a hold-up is the symbol for a sexual assault; ships, stoves, etc., are symbols for sex organs, etc., etc. Dreaming of any of these symbols, whose number is great, means dreaming of sex. With such an equipment what cannot be proven! Furthermore, the consideration of *resistance* goes a long way: if the patient admits or alludes to an urge in a remote way, good and well; if the resistance prevents even a remote allusion, the resistance itself is proof of the underlying urge—tails I win; heads you lose.

"In psychoses, however, the turning away from reality is brought about in two ways; either because the repressed unconscious is too strong, so that it overwhelms the conscious

which tries to cling to reality, or because reality has become so unbearably painful that the threatened ego, in despairing gesture of opposition, throws itself in the arms of the unconscious impulses."[2] Here with the unconscious bared to light we would expect the full exposure of those submerged complexes. But it so happens that in such instances—in the psychoses—the unconscious does not live up to its reputation. Over seventeen years of daily contact with the insane have convinced the writer that the mental contents of these patients, especially the schizophrenics, are far less sex-beset than those of normal individuals. As to the Oedipus and castration complexes, they never heard of them. The patient frequently turns against both parents, and not for sexual reasons but, usually, because of imaginary persecution. He similarly turns against his townfolks, acquaintances, the Masons, the Elks, etc., etc., because of the same reason.

As to the success of the psychoanalytical theory at explaining the phenomena, the following will suffice: Freud "admits himself still (being) baffled and unable to throw light 'after decades of analytical investigation' upon the *leit motiff* of the neuroses."[3]

How can the theory explain the fact that the dog is unmistakably affectionate towards his master? That theory assumes that affection is an "aim-inhibited" sexual urge—inhibited by the superego. Does the dog also have a superego? What for? His social laws and morals are simple enough; and he lives up to them.

"Analytical therapy can be applied (to) transference neuroses, hysterias, obsessional neuroses, and besides these, such abnormalities of character as have been developed instead of these diseases. Everything other than these, such as narcistic and psychotic conditions is more or less unsuitable."[2] "The treatment of a serious neurosis may take several years."[2] We see, accordingly, that psychoanalysis can be successful only in those neuroses which are usually summed up under hysteria, cases which are as successfully treated by means of charms, amulets, incantations, horse-shoes, magnets, visits to certain shrines, graves, etc., etc.,—by whatever the patient happens to believe in.

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The Platform of the American Medical Association

The American Medical Association advocates:

1. The establishment of an agency of the federal government under which shall be coördinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy.

2. The allotment of such funds as the Congress may make available to any state in actual need, for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.

7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.

8. Expansion of public health and medical services consistent with the American system of democracy.

Plan for Medical and Hospital Care for Wives and Infants of Men in Military Service

On March 27, 1942, the State and Territorial Health Officers met in Washington, D. C., and recommended that State Health Agencies develop plans to finance from Maternal and Child Health funds the medical and hospital obstetric and pediatric care needed by wives and children of men in military service unable to purchase such care.

The following plan for use in the State of Maine has been made and submitted to and approved by the U. S. Children's Bureau.

1. *Eligibility:*

All expectant mothers in the state, irrespective of legal residence, who state that the father of the expected child is in military service (U. S. Army, or U. S. Navy, including Marine Corp, and Coast Guard) and not a commissioned officer shall be eligible for obstetric medical and hospital services provided under the MCH program without cost to the family whenever, to the knowledge of the State Bureau of Health, such services are not otherwise readily available to the patient. In instances of need for especial medical care or continued hospitalization for the newborn infant because of prematurity or illness, such services may be provided. This service applies only to the infant born on this medical and hospital care plan.

No social service investigation shall be made by the state to determine whether obstetric medical care is otherwise available to the patient, but it will be requested that the agency referring the case determine whether or not such services are readily available before approval is made.

2. *Authorization:*

Authorization for this service shall be made by the Division of Maternal and Child Health on approval of two application forms (Parts 1 and 2 of Form M) the first part of which is filled out by the patient, and the second by the physician referring the case. These application forms will be distributed to State Health and Welfare agencies, official and non-official, upon request made to the Division of Maternal and Child Health, State Bureau of Health, Augusta. Upon receipt of the application forms and approval by the Division of Maternal and Child Health, notification will be given to the patient, attending physician, hospital (either for prenatal service and delivery service through Prenatal Clinic or for hospitalization recommended by attending physician) and the District or local public health nurse in whose territory the patient lives. Request for extension of medical care and/or hospitalization of the newborn infant shall be made by application to the Division of Maternal and Child Health and approved by the Director.

3. *Standards of Medical Care:*

Medical care under the plan will be authorized by the Division of Maternal and Child Health, only when the attending physician is licensed to practice in the state and is a graduate of a medical school approved by the Council on Medical Education of the American Medical Association. High standards of prenatal care will be encouraged through articles in the state medical journal, distribution of the Children's Bureau publication on Standards of Prenatal Care and direct supervision whenever possible. Efforts will be made to secure the services of obstetricians or pediatricians, as the need may be, whenever possible.

4. *Standards of Hospital Care:*

Hospital care shall be authorized only in hospitals approved by the American College of Surgeons or meeting the requirements of the State Bureau of Health for maternal care cases including provisions for pediatric and premature care of the newborn infants.

5. *Administration and Cost of Medical and Hospital Care:*

Patients applying for obstetric medical services from Prenatal Clinics where hospitalization facilities are available shall be referred by the clinic physician. Prenatal and postpartum care under this type of service will be

given as usual through the Prenatal Clinic and delivery shall be "on service" at the hospital. Payment for these cases will be made by the Division of MCH to the hospital at the prevailing ward day rate for a minimum of ten days hospitalization, no delivery fees to be paid. The per diem ward rate shall include delivery room, care of the infant and laboratory services and drugs. When a patient is eligible for State Hospital Aid, the prevailing hospital aid day rate will be deducted from the hospital ward day rate and the balance paid to the hospital by MCH funds.

In hospitals near Army camps where Army physicians attend wives of men in service, patients may be delivered by the Army physicians in hospitals meeting the requirements as stated above and payment or balance of payment made to the hospital for hospitaliation alone.

Obstetric medical care for patients applying outside of Prenatal Clinics will be arranged through the referring physician and paid for at the rate of $35.00 for prenatal care (minimum, five examinations covering preferably the last trimester, but at least the last two months of pregnancy) and including labor, the puerperium(and care of newborn infant) and the postpartum examination.

Hospital rates will be paid at the current per diem ward rate. For medical services including delivery, the puerperium and postpartum examination alone, without prenatal care, a fee of $25.00 will be paid.

Medical care and hospitalization of the newborn infant for an extended period or after discharge of the mother from the hospital, shall be approved by the Director of Maternal and Child Health only after application has been made by the attending obstetrician or pediatrician and shall be paid for at the prevailing ward nursery day rate for the infant alone.

Medical consultation for obstetric or pediatric care may be requested by the attending physician and approved by the Division of Maternal and Child Health. Requirements for obstetric consultants shall include those general qualifications listed for Maternal and Child Health Consultants in the 1940 plan covering the Demonstration Area and shall cover:

Graduation from a medical school approved by the Council on Medical Education of the American Medical Association with special graduate training in obstetrics, practice limited to obstetrics and preferably certified by the American Board.

Pediatric Consultants will be required to meet the qualifications set up in the 1942-43 annual plan. Payment for services of obstetric or pediatric consultants will be made according to such services already established and described in the annual plan (1942-43, page 11).

Payment will be made to the physician or hospital upon receipt of the completed maternity record Form 16-17174—U. S. Government Printing Office. These forms may be obtained from the Division of Maternal and Child Health, State Bureau of Health, Augusta. Such records will be kept on file in the office of the Division of Maternal and Child Health.

By October, 1942, State and Territorial health departments had requested from the U. S. Children's Bureau funds amounting to more than $1,500,000 to provide obstetric and pediatric medical care and hospital care for the families of men in military service. Plans had been received from twenty-five states and Hawaii and most of these had been approved and were in operation:

Alabama	New Jersey
Arkansas	New Mexico
California	North Carolina
Hawaii	Oklahoma
Idaho	Rhode Island
Illinois	South Carolina
Indiana	South Dakota
Maine	Texas
Maryland	Utah
Minnesota	Virginia
Mississippi	Washington
Missouri	Wisconsin
Nebraska	Wyoming

The percentage of all babies born whose fathers are in military service is already substantial and is on the increase. For the twenty-eight states submitting plans preliminary figures based on birth certificates filed during May, June, and July, 1942, show a

Continued on page 20

Editorial

War Problems to Be Discussed by Industrial Health Congress

Program of Jan. 11-13 Meeting in Chicago Designed to Show How Industrial Health Services Can Be Extended and Improved

One of the most important medical problems of the Nation's war effort, the health of industrial workers, will engage the attention of the leaders in that field at the Fifth Annual Congress on Industrial Health, sponsored by the Council on Industrial Health of the American Medical Association, to be held January 11-13 at the Palmer House, Chicago.

Discussing the program for the congress, *The Journal* of the Association, in an editorial in its December 5 issue, says:

"The problems associated with the maintenance of industrial health continue to attract increasingly the attention of physicians, employers, workers and governmental agencies. Indeed, the hearings before the Pepper committee on education and labor served to focus the public eye on the situation. The program for the fifth Annual Congress on Industrial Health . . . has been designed to illustrate how industrial health services can be extended and improved.

"Th demand for industrial health service has increased at a time when the facilities and personnel of medicine cannot assign the numbers of physicians and technicians necessary for ideal coverage. Intensified organization for the certification and training of physicians essential to industry becomes necessary; these plans will be discussed during the congress. The growing influence of labor in the industrial health program will be represented by a description of activities currently under way by employee-management production drive committees now organized in more than sixteen hundred plants at the request of the War Production Board.

"A symposium on Infections in Industry will be conducted jointly with the Council on Pharmacy and Chemistry [of the American Medical Association] to include not only those of definite occupational origin but also others causing serious loss of time in industry, notably those affecting the upper respiratory system.

"Another significant development in industrial practice is the changing nature of the work force; men are being replaced by women, older men, young workers and the handicapped. Each presents a new and different group of health problems.

"Another session of the congress has been assigned to industrial medicine and the emergency. Here recent experience in functioning with less well trained help, the possibility of using technicians and aides to a greater extent as replacements for more skilled people, more effective use of medical records as guideposts to needed preventive medicine and hygiene, and closer association between industrial medical facilities and those being set up for emergency medical care under the Office of Civilian Defense will be elucidated.

"Innovations during this congress will be symposiums on Medical Relations in Workmen's Compensation, jointly presented with the Bureau of Legal Medicine and Legislation [of the American Medical Association], and on Recent Developments in Rehabilitation, presented jointly with the Council on Physical Therapy [of the Association].

"On the last day a round table on Nutrition of Industrial Workers will be held in company with the Council on Foods and Nutrition [of the Association] and interested personnel from the National Research Council and the United States Public Health Service. Directly following this symposium a conference on industrial health to which the public will be invited will be held under the joint auspices of committees of the Chicago

Medical Society and the Illinois Manufacturers' Association. Many other state and local organizations will collaborate.

"An exhibit is planned which will demonstrate the industrial health services now available through agencies in organized medicine, public health and a few independent agencies. According to present plans, about thirty exhibits will be shown.

"Once again this program reveals the desirability of focusing the attention of almost every phase of medical activity on the health problems of industry."

Attention, Please!

"It is of the utmost importance that the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians, immediately has the name of any doctor who really is willing to be dislocated for service, either in industry or in over-populated areas, and who has not been declared essential to his present locality. This is necessary if the medical profession is to be able to meet these needs adequately and promptly. We urgently request that any physician over the age of 45 who wishes to participate in the war effort send in his name to the State Chairman for the Procurement and Assignment Service in his State."

Maternal and Child Welfare

The Newborn

The management of the newborn really begins with prenatal care. The mother is given adequate iron, calcium, and vitamines, and examined to make sure that her pelvis will permit the birth of an undamaged infant. The second stage of labor should be conducted with a view to reducing to a minimum the trauma to the baby's head, providing, of course, that nothing threatens the monther's life. Particularly, your committee urges that pituitrin be not given before the baby is born for fear of cerebral hemorrhage or asphyxia.

In the delivery room the concern of the doctor in regard to the baby is to prevent infection, avoid loss of body heat, and establish respiration. As soon as the head is born, wipe the vaginal mucus off the eyelids with a pledget of moist cotton. After birth the infant is laid on a sterile sheet and covered with a sterile towel to prevent heat loss. Ordinarily the cord is not tied until it stops pulsating so that the infant may receive all the blood that is coming to him. The air passages are cleared of mucus and amniotic fluid before the first breath if possible. Be gentle. Do not suspend the baby by the heels if there is any possibility of cerebral hemorrhage. If suction is not available, a soft rubber ear

syringe will be found helpful. Before the infant leaves the ledivery room put a drop of 1% silver nitrate in each eye, inspect the cord, and note the quality of the respiration.

Asphyxia neonatorum is not caused by a low content of oxygen in the blood and tissues alone but also by either a low carbon dioxide content or a respiratory center depressed so much that more carbon dioxide than normal is required to stimulate it. The primary cause is oxygen deficiency since oxygen is necessary to produce carbon dioxide. The causes of congenital asphyxia may be roughly grouped into those involving the respiratory center and those causing obstruction to the foetal circulation or the respiratory tract directly. (We are not now discussing acquired asphyxia). Asphyxia livida is usually of obstructive origin, and asphyxia pallida of central origin. The respiratory center may be rendered less responsive by the pressure of labor, especially prolonged labor, or it may be depressed by opiates, analgesics and anesthetics. Your committee urges discretion in the use of drugs, especially toward the end of labor.

The causes of interference with the foetal circulation may be maternal in origin as hemorrhage, cardiac decompensation, pneumonia, or interruption of circulation at the placental site by the contracting uterus. This last is more likely to occur in dry labors and in cases where pituitrin is used before the birth of the infant. The foetal causes of asphyxia include cardiac defects, tumors, aspirated material obstructing the air passages, and abnormalities in the cord, kinks, knots, etc. Prematurity is a common indirect foetal cause.

Violent foetal activity at term or in labor is very suggestive of early foetal asphyxia. Foetal bradycardia, irregularity of heart sounds, weakness, later rapidity, and the passage of meconium in vertex presentations are pathognomonic signs. Foetal heart rates over 160 or under 100 indicate impending asphyxia. Obviously, these signs have to be looked for.

Asphyxia livida presents cyanosis in varying degree, the respirations are irregular or absent, and the infant is motionless. Muscle tone is present, however, and the skin is warm. In the pallid type the infant is pale with perhaps some cyanosis of the lips, cold, and limp, looking like a corpse. He is obviously in a serious condition. The appearance simulates severe brain injury so closely that differentiation is usually impossible except by the outcome.

Resuscitation of the asphyxiated newborn depends on adherence to five principles: clear the air passages, supply warmth, supply oxygen, stimulate respiration, be gentle. The first act, regardless of the presence or absence of asphyxia is to clear the air passages. The baby may be held with the head lower than the hips and the trachea milked upward to drain mucus and amniotic fluid into the throat whence it is removed by the gloved finger, or by suction. Gentleness is required.

Supplying warmth is necessary because newborns have a subnormal temperature which is even lower in the asphyxiated. Cover the infant with warm wraps or place him in warm water. Test the temperature. If a thermometer is not available, use the elbow. Take care to avoid chilling when he is removed. The use of a cold bath to stimulate respiration is absolutely contraindicated.

Oxygen is often life-saving. It may be given in almost any manner providing that such pressure is not used as to risk rupture of the alveoli. It is well to run it through a bottle of warm water both to estimate the rate of flow and to avoid chilling the face and air passages.

For stimulating respiration after obstructing material has been removed simple measures may be used first. The skin is gently patted or rubbed. The cord is clamped and a few drops of cool water or ether sprinkled on the chest. If the infant begins to breath shallowly and irregularly, a few whiffs of aromatic spirits of ammonia may produce the desired cry. If carbon dioxide is available it may be used to stimulate the respiratory center in the proportion of five percent of the gas to 95 percent oxygen. Bubble it gently through water to a funnel or mask placed over the face. Be moderate. Do not overdo it for fear of producing acidosis.

When the gases are not available and the infant is breathing feebly it may be permissible to use artificial respiration. Remem-

ber that it is of no use unless the infant has breathed, and that he must be kept warm. A good method is as follows: support the back with one hand, the thumb and forefinger controlling the neck. The other hand supports the thighs. Flex the body so that the head and feet are brought together. This produces expiration. Unfolding the body produces inspiration. The rate should be ten to twenty to the minute. Be gentle. There is a certain amount of danger that blood will be pumped to the head with resulting aggravation of a cerebral hemorrhage. Violent measures such as swinging the baby should not be used.

As a last resort insufflation may be used with great care. If the gas mixture is used by intratracheal catheter the pressure must be reduced to ten or fifteen millimeters of mercury. If mouth to mouth insufflation is used, take precautions against infection and also against too great pressure.

(To be continued)

Your Committee on Maternal and Child Welfare.

The Treatment of Burns—Continued from page 3

The compression is particularly valuable in preventing the invisible and insensible "bleeding" which occurs into the surrounding tissues and which has been shown to occur by such workers as Blalock, Harkins, Gunther, Elkinton, and others.[5]

Fresh second degree burns which have been properly cleaned and which have been covered with this type of dressing will usually show complete epithelialization after 10 to 14 days when the initial dressing is first removed. If infection should occur the dressing can easily be removed and appropriate measures taken for it is non-adherent.

If the burn has resulted in complete destruction of the skin, of course no epithelial regeneration can occur except by growth in from the periphery and if the defect is at all large, skin grafting should be resorted to. This will shorten the convalescence and prevent excessive scar formation. As soon as the necrotic tissues can be removed they should be excised and granulation tissue growth encouraged by warm saline dressings so grafting can be done early to prevent contractures, to prevent tendon slough, and hasten the time when any reconstructive work that is necessary can be done.

Burns about the buttocks, perineum, and genitalia are treated with difficulty by any type of dressing because of the position and the danger of contamination. Here one of the rapid tanning agents or the use of an ointment with one of the sulfonamides after cleansing are perhaps the methods of choice.

It is reported that 60% of the casualties at Pearl Harbor were burns. Modern warfare with its mechanized equipment and use of inflammable materials produces a tremendous number of burn casualties. Under emergency conditions the treatment as outlined here may not be feasible and some sort of emergency dressing must be applied.

What type of dressing is to be applied will depend upon the facilities and time available when first aid is given. Certainly it is not unreasonable to expect that the burned areas be covered with some sterile compression dressing and that all those in attendance at an open wound be properly masked so as to prevent further contamination by the virulent organisms from their upper respiratory tracts.

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Necrologies

James P. Blake, M. D., 1865-1942

James P. Blake, M. D., 77, of Harrison, Maine, died December 8, 1942, in a Portland hospital after an illness of two weeks.

He was born at Harrison, October 3, 1865, the son of Cyrus and Clara Richardson Blake. He was graduated from Bridgton Academy, and from Bowdoin Medical School in 1892.

Doctor Blake was a member of the American Medical Association, the Maine Medical Association, and the Cumberland County Medical Society. At the June, 1942, annual session of the Maine Medical Association he was presented with the Association's gold medal in recognition of fifty years in the practice of medicine.

He was a member of Oriental Lodge of Masons at Bridgton, and the Odd Fellows lodge at Harrison.

He is survived by his widow, Mrs. Gertrude Blake.

Ralph Hemenway Marsh, M. D., 1863-1942

Ralph Hemenway Marsh, M. D., 79, died at his home in Guilford, Maine, October 27, 1942, following an illness of several years.

He was born at Greenville, Maine, February 3, 1863, the son of Martin V. B., and Paulena C. Foss Marsh, and was graduated from the University of Maine in 1888, and from Bowdoin Medical School in 1893. He practiced medicine in Lincoln for one year following his graduation and then moved to Guilford where he practiced general medicine and surgery up to October 1, 1942, but was forced to curtail his practice during the past few years because of failing health.

The death of Doctor Marsh has removed one of the few remaining "country doctors" in this part of Maine, for though he kept in touch with the latest developments in his profession he was still the "country doctor," and gave his best at all times and under all circumstances.

Doctor Marsh was a member of the American Medical Association, the Maine Medical Association, and the Piscataquis County Medical Society, and was a past president of the State and County groups. He had served as county medical examiner and special pension examiner, and was on the Medical Advisory Board of his district during World War I.

At the June, 1942, annual session of the Maine Medical Association, he was presented with the Association's gold medal in recognition of fifty years in the practice of medicine.

Doctor Marsh was a Past Master of Mt. Kineo Lodge, F. & A. M., a member of Piscataquis Royal Arch Chapter and a 32nd degree Mason. He was also a member of Almeda Chapter, O. E. S., and of the Odd Fellows. He had served as president of the Guilford Chamber of Commerce and of the Senior Alumni Association of the University of Maine. He was a member of the Universalist church and prominent in all its activities.

He is survived by his widow, Myrtle Alice Holbrook Marsh, a daughter, Miss Alice H. Marsh, and a brother, S. N. Marsh, M. D., of Bangor.

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County News and Notes

Paid-Up Membership for 1943

Piscataquis County Medical Society

Kennebec

The annual meeting of the Kennebec County Medical Association was held at the Augusta State Hospital, Augusta, Maine, Thursday, December 10, 1942.

Clinical session at 5:00 P. M. Presentation of cases by members of the Staff.

Dinner at 6:30 P. M., which was followed by a business meeting. Minutes of the last meeting were read and approved. The reports of the Secretary-Treasurer were read and accepted.

Officers for the ensuing year were elected as follows:

President: A. J. Gingras, M. D., Augusta.

President-Elect: Clarence R. McLaughlin, M. D., Gardiner.

Secretary-Treasurer: C. S. Bauman, M. D., Waterville.

Councilors: T. C. McCoy, M. D., Waterville; A. W. Moore, M. D., Mt. Vernon; E. H. Jackson, M. D., Augusta.

Delegates to the Maine Medical Association: B. O. Goodrich, M. D., Waterville; I. E. McLaughlin, M. D., Gardiner; Frank Bull, M. D., Gardiner; L. Armand Guite, M. D., Waterville. Alternate: Chalmers G. Farrell, M. D., Gardiner.

Applications for membership of Harry Elkins, M. D., Augusta, and Kurt A. Sommerfeld, M. D., Gardiner, were received and referred to the Council.

The speaker of the evening was Forrest C. Tyson, M. D., Superintendent of the Augusta State Hospital, whose subject was *Dementia Praecox* with special reference to men inducted into military service who have since been committed to the State Hospital. This paper was ably presented, and brought out many interesting facts. Discussion was opened by George E. Heels, Captain, M. C., Medical Officer, Recruiting and Induction Station, Portland, Maine. This was followed by a general discussion.

There were 32 members and guests present.

Respectfully submitted,
FREDERICK R. CARTER, M. D.,
Secretary.

Penobscot

The regular meeting of the Penobscot County Medical Association was held Tuesday, December 15, 1942, at the Bangor House, Bangor, Maine. Following a dinner at 6.30 P. M., a scientific session was held.

The speaker of the evening was B. Earl Clarke, M. D., Pathologist, Rhode Island Hospital, Providence, Rhode Island, whose subject was *The History of the Microscope and Early Microscopy.*

FORREST B. AMES, M. D.,
Secretary.

Piscataquis

A regular meeting of the Piscataquis County Medical Association was held at the New Milo Hotel, Milo, Maine, Wednesday, November 18, 1942.

At 6.30 P. M., a banquet was served to the doctors and their ladies, which was followed by a business meeting.

A committee was appointed to draw up resolutions on the death of Ralph H. Marsh, M. D., of Guilford. Doctor Marsh was a past president of the Maine Medical Association, and of the county society. He received his Fifty-year medal at the 1942 annual meeting of the Maine Medical Association at Poland Spring.

The guest speaker for the evening was Lt. Allan Stinchfield, M. C., U. S. A., who presented an interesting talk on *Chemical Warfare*.

H. C. Bundy, M. D.,
Secretary.

*Members in Military Service**

Cumberland

Douphinett, Otis J.,	Portland
Leighton, Wilbur F.,	Portland

Hancock

Trowbridge, Mason,	Ellsworth

Kennebec

Pratt, T. Dennie,	Waterville

Penobscot

Butler, Harry,	Bangor
Miragliuolo, Leonard G.,	Bangor
Osler, Jay K.,	Bangor
Smith, John E.,	Bangor
Todd, Albert C.,	South Brewer

Waldo

Caswell, John A.,	Belfast

* For complete list see September, October, November, and December, 1942, Journals.

Notices

State of Maine

Board of Registration of Medicine

Adam P. Leighton, M. D., Portland, Secretary.

List of Physicians Licensed by the State of Maine, Board of Registration of Medicine, November 4, 1942.

Through Examinations

Harry Analis, M. D., 10213 North Boulevard, Cleveland, Ohio.

Melvin Bacon, M. D., 12 Grant Street, Haverhill, Mass.

Ana Balfour, M. D., Vinalhaven, Maine.

Henry Clinton Becker, M. D., 312 West 103rd Street, New York City.

Robert Miles Burns, M. D., Windham, Maine.

Harry Elkins, M. D., P. O. Box 724, Augusta, Maine.

Frederick Clayton Emery, M. D., 79 Gainsborough Street, Boston, Massachusetts.

Louis Gitzelter, M. D., Welfare Hospital, Welfare Island, New York City.

George Jewett Harrison, M. D., 38 Pleasant St., Houlton, Maine.

Wilmot Leighton Marden, M. D., 16 Audubon Park, Lynn, Massachusetts.

Eugene Cyril McCann, M. D., 103 Pleasant Ave., Portland, Maine.

John H. T. McPherson, Jr., M .D., 219 Park Drive, Boston, Massachusetts.

Nathaniel Mills, M. D., Harrison, Maine.

Robert Sommer, M. D., 77½ Congress Street, Portland, Maine.

George H. Taft, M. D., Fort Williams, Maine.

Through Reciprocity

Dorothy S. Anderson, M. D., Caribou, Maine.

M. Eleanor Blish, M. D., Augusta, Maine.

Miriam Doble Cary, M. D., Bath, Maine.

David V. Mann, M. D., Randolph, Massachusetts.

James Philip Parlante, M. D., Bradley, Ohio.

William G. Thompson, M. D., 10 Congress Square, Portland, Maine.

Peter W. Wheeler, M. D., 443 Congress Street, Portland, Maine.

Bureau of Health

Services for Crippled Children
Clinic Schedule

Waterville: *Thayer Hospital*
Thursday, 1.30-3.00 P. M.: December 31, February 25, April 22, June 24, August 26.

Rockland: *Knox County Hospital*
Thursday, 1.30-3.00 P. M.: February 18, May 20, August 19.

Portland: *Children's Hospital*
Monday, 9.00-11.00 A. M.: December 14, January 11, February 8, March 8, April 12, May 4, June 14, July 12, August 9.

Fort Kent: *Normal School*
Tuesday, 9.00-11.00 A. M.: May 11, August 17, November 30.

Houlton: *Aroostook General Hospital*
Tuesday, 9.00-11.00 A. M.: June 29, October 5.

Presque Isle: *Northern Maine Sanatorium*
Wednesday, 9.00-11.00 A. M., 1.00-3.00 P. M.: May 12, June 30, August 18, October 6, December 1.

Lewiston: *Central Maine General Hospital*
Friday, 9.00-11.00 A. M.: December 18, January 22, February 26, March 26, April 23, May 28, June 25, July 23, August 27.

Rumford:* *Rumford Community Hospital*
Wednesday, 1.30-3.00 P. M.: January 20, April 28, July 21.

Machias: *Normal School*
Wednesday, 1.30-3.00 P. M.: January 13, April 14, July 14.

Portland Cardiac: *Children's Hospital*
Tuesday, 9.00-11.00 A. M.: December 8, December 22, January 12, January 26, February 9, February 23, March 9, March 23, April 13, April 27, May 11, May 25, June 8, June 22, July 13, July 27, August 10, August 24.

Lewiston Cardiac: Temporarily discontinued due to War.

* Note change in date of next clinic and the new interval between clinics.

Please destroy previous schedule.

Tumor Clinics

Bangor: *Eastern Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Magnus F. Ridlon, M. D.*

Lewiston: *Central Maine General Hospital*
Tuesday, 10.00 A. M.-12.00 M.
Director, *E. C. Higgins, M. D.*

St. Mary's General Hospital
Wednesday, 4.00 P. M.
Director, *R. A. Beliveau, M. D.*

Portland: *Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Mortimer Warren, M. D.*

Waterville: *Sisters Hospital*
1st & 3rd Thursdays, 10.00 A. M.
Director, *B. O. Goodrich, M. D.*

Thayer Hospital
2nd & 4th Thursdays, 10.00 A. M.
Director, *E. H. Risley, M. D.*

Venereal Disease Clinics

For the information of physicians wishing to refer cases of venereal disease for treatment, the State Bureau of Health announces that such facilities are available in the following locations:

Augusta, Bangor, Bath, Belfast, Biddeford, Bingham, Calais, Danforth, Eastport, Ellsworth, Grand Isle, Guilford, Houlton, Island Falls, Lewiston, Millinocket, Old Town, Portland, Presque Isle, Rockland, Rumford, Sanford, Waterville, Wilton, Winthrop.

Any physician wishing to refer a case may obtain the name of the clinic physician, in the town where the patient is to receive treatment, on request to the Director, State Bureau of Health, Augusta, Maine.

Plan for Medical and Hospital Care for Wives and Infants—Continued from page 12

total of 309,357 births of which 9,176 or 3% were children of men in military service. In Maine, 4,480 births were registered for this period and 160 or 3.6% were children of men in military service.

The Children's Bureau has information which indicates that the proportion of married men in the armed forces more than doubled from December, 1941, to April, 1942. Indications are that the increase is continuing. On the basis of this information and the figures given above, it may be conservatively estimated that 5% of the births in the United States in the year beginning July, 1942, will be to the wives of men in the armed forces.

Pay Your 1943 State and County Dues Promptly to Your County Secretary

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Book Reviews

"Surgical Practice of the Lahey Clinic, Boston, Massachusetts"

376 Illustrations.

Published by W. B. Saunders Company, Philadelphia and London, 1941. Price, $10.00.

This book is composed of the work performed by the co-authors, twenty-four of them, while serving at the Lahey Clinic. It represents a fair cross-section of the methods and technics of diagnostic measures, surgical procedures, and their end-results. The methods described and illustrated represent an attempt at standardization of surgical technic for similar types of surgically correctable conditions. The subject matter included in this volume comprises articles on the Thyroid Gland; Esophagus and Lungs; Breast; Stomach, Duodenum and Small Intestine; Biliary Tract; Colon, Sigmoid and Rectum; Pelvis; Kidney and Prostate Gland; Bones and Joints; Brain, Spinal Cord and Nerves; also various types of Anesthesia. Those who know the excellent work performed at the Lahey Clinic know that everything contained in this book is of practical value to all those who practice good surgery.

"Arthritis in Modern Practice"

The Diagnosis and Management of Rheumatic and Allied Conditions

By: Otto Steinbrocker, B. S., M. D., Assistant Attending Physician and Chief, Arthritis Clinic, Bellevue Hospital, Fourth Medical Division, New York City.

With Chapters on Painful Feet, Posture and Exercises, Splints and Supports, Manipulative Treatment and Operations and Surgical Procedures by John G. Kuhms, A. B., M. D., F. A. C. S., Chief of the Orthopedic and Surgical Service, Robert Breck Brigham Hospital; Assistant Visiting Orthopedic Surgeon, Boston Children's Hospital.

Illustrated.

Published by the W. B. Saunders Company, Philadelphia and London, 1941. Price, $8.00.

Here is a most thorough-going textbook on the various phases of the various types of rheumatic and allied diseases. The authors have brought together all the information available at this time concerning causes, diagnoses, management, treatment and re-educative manipulation of all forms of painful afflictions, usually included within the large group of complaints called rheumatic disorders.

The first sixteen chapters give detailed description of a great many rheumatic complaints. The next two chapters deal with special therapeutic measures and techniques. Chapter 20 limits its attention to painful feet and their care. The next four chapters take up postural, supportive, manipulative and surgical procedures. Chapter 25 contains an excellent glossary of data specially attributable to work done in the study of the rheumatic disorders.

Since almost 7,000,000 of the population of the United States seek the physicians' services for rheumatic pains almost every year and since the book under review contains almost all available information, the work fills a long-felt need in modern medical literature.

"The March of Medicine"

New York Academy of Medicine Lectures to the Laity, 1941

Published by Columbia University Press, New York, Morningside Heights, 1941. Price, $2.00.

This is the sixth of a series of publications of "Lectures to the Laity." Without question the Academy of Medicine has rendered a significant service to the public. More than that, almost every one of these lectures is filled with gems of wisdom expressed in beautiful and readily absorbable style which should make enjoyable reading for physicians everywhere. This is especially true of the lectures on "Humanism and Science" and "Philosophy as Therapy."

"The Toxemias of Pregnancy"

By: William J. Dieckmann, M. D., Associate Professor of Obstetrics and Gynecology, The University of Chicago; Attending Obstetrician, The Chicago Lying-in Hospital and Dispensary; Attending Gynecologist, Albert Merrit Billings Memorial Hospital of the University of Chicago; Associate Editor of the "American Journal of Obstetrics and Gynecology"; Co-chairman of the Conference on Eclampsia, United States Department of Labor, Children's Bureau, 1941.

With Fifty Text Illustrations and Three Color Plates.

Published by The C. V. Mosby Company, St. Louis, 1941. Price, $7.50.

Convulsive attacks complicating pregnancy have been recorded in medical literature since the days of Hippocrates. Many essays have been written from then until now. Never before, however, has it been the privilege of this reviewer to study such a comprehensive monograph as this. Eclampsia is viewed and thoroughly described from all known aspects. The book has been written primarily to acquaint the obstetrician with some of the recent contributions on physiology as it pertains to obstetrics and secondarily to acquaint the investigator, untrained in obstetrics, with some of the physiology and pathology of obstetrics. This is a truly monumental work on eclampsia and related complications which may afflict the pregnant and child-bearing woman.

"Synopsis of Allergy"

By: Harry L. Alexander, A. B., M. D.; Professor of Clinical Medicine, Washington University School of Medicine, St. Louis; Editor of "The Journal of Allergy."

Illustrated.

Published by The C. V. Mosby Company, St. Louis, 1941. Price, $3.00.

This book is a synoptic presentation of present-day thought concerning allergy. To most clinicians complaints thought to be due to allergy include hay fever, bronchial asthma, vasomotor rhinitis, urticaria, eczema, migraine and various gastro-intestinal disturbances. It all is a large and only recently developed field in the study of which much has been written which cannot always be backed up with scientific proof. The author of this little book tells the reader tersely what is known of allergic diseases.

"Woman's Personal Hygiene — Modern Methods and Appliances"

By: Leona W. Chalmers.

Foreword by Winfield Scott Pugh, B. S., M. D.

Published by Pioneer Publications, Inc., New York, 1941. Price, $2.00.

This book is written by a lay woman who feels called upon to give instruction to her fellow beings in the art of achieving her personal aim; namely, "to be esteemed as lovely, amiable and desirable." Being the daughter of a physician's daughter encourages the author to give rather more semi-professional and professional advice than is usually deemed wise but since some information seems to be needed on the subject of feminine hygiene she is perhaps better qualified than some others might be. This book is a sequel to "The Intimate Side of a Woman's Life," published a few years ago.

"The Blood Bank and the Technique and Therapeutics and Transfusions"

By: Robert A. Kilduffe, A. B., A. M., M. D., F. A. S. C. P.; Director, Laboratories, Atlantic City Hospital; City Bacteriologist, Atlantic City; and Michael De Bakey, B. S., M. D., M. S., F. A. C. S.; Assistant Professor of Surgery, School of Medicine, Tulane University of Louisiana.

With 214 Illustrations.

Published by The C. V. Mosby Company, St. Louis, 1942. Price, $7.50.

The transfusion of blood and other fluids for the preservation of human life has been a subject of investigation among practitioners of medicine for many centuries. Only during the recently past century, however, have techniques been sufficiently perfected so that the life to be saved could be saved without the price of death of either the donor or the recipient after a comparatively short time after the completion of the successful operation.

In the book under review the authors have brought together into one volume almost all that is known on the subject of blood transfusion and subjects directly and indirectly related to it. The text is most efficiently enlarged with more than 2,800 appropriate bibliographical reference entries. Nothing like it has been seen in circulation up to now.

"A Primer on the Prevention of Deformity in Childhood"

By: Richard Beverly Rancy, B. A., M. D.; Associate in Orthopædic Surgery, Duke University School of Medicine, Durham, N. C.; Attending Orthopædic Surgeon, Watts Hospital, Durham, N. C.; In Collaboration with Alfred Rives Shands, Jr., B. A., M. D.; Medical Director, Alfred I. du Pont Institute of The Nemours Foundation, Wilmington, Delaware.

Illustrated by Jack Wilson.

Published by National Society for Crippled Children, Inc., Elyria, Ohio, 1941. Price, $1.00.

The children with deformities of the bony structures represent the heart of orthopedics. The small book under review is filled with instructions for the correction of all correctable deformities due to disease, injury, maldevelopment, etc., among children. It is written in plain language and with a view to supply those persons, who first come in contact with the sick child threatened with possible deformity, with information that will enable them to provide preventative measures against such deformation. There are many illustrations showing the application of corrective devices in cases where deformation has already taken place.

"Encephalitis — A Clinical Study"

By: Josephine B. Neal, A. B., M. D., Sc. D., F. A. C. P.; Associate Director, Bureau of Laboratories, Department of Health, New York; Clinical Professor of Neurology, College of Physicians and Surgeons, Columbia University; With Collaborators: Lauretta Bender, M. A., M. D.; Helen Harrington, M. A., M. D.; Ralph S. Muckenfuss, B. S., M. D.; Tracy J. Putnam, A. B., M. D.; Albert A. Rosner, A. B., M. D.; Lewis D. Stevenson, A. B., M. D.

Foreword by Hubert S. Howe, A. M., M. D.

Published by Grune & Stratton, New York, 1942.

This volume is a comprehensive work of research on the various forms of encephalitis. It was made possible by a grant from the William J. Matheson Commission for Encephalitis Research. It is very timely and most welcome. It is thoroughgoing. It is authoritative. For more than eleven years Dr. Neal has followed the various presentations of the disease in more than seven hundred patients under her personal supervision. It is not known that any other investigator has had more experience in this field than has the editor of this classic. With her co-authors she has presented the medical profession with a textbook which contains present day knowledge of all phases of the disease group called encephalitis. It is very valuable to the general practitioner, the pediatrician and the general health officer.

"Diseases of Metabolism — Detailed Methods of Diagnosis and Treatment"

A Text for the Practitioner

Edited by: Garfield G. Duncan, M. D., Chief of Medical Service "B", Pennsylvania Hospital; Associate Professor of Medicine, Jefferson Medical College, Philadelphia, Pennsylvania.

With 15 Contributors.

Illustrated.

Published by W. B. Saunders Company, Philadelphia and London, 1942.

This very comprehensive textbook is specially written to provide the general medical practitioner with reliable basic information which is to enable him to understand, diagnose and treat the various metabolic diseases. The fundamentals providing such information have been reviewed, reinterpreted according to recently completed laboratory work. Naturally, the presentation of a large work on a large subject such as metabolism, normal and abnormal, cannot go into all the details which preceded the formulation of conclusions, nor can all interrelated subjects be treated in full detail. Nevertheless, almost every phase of metabolism, as it affects mankind, has been thoroughly studied and presented in expert fashion so that all the theories and facts are readily available and therapeutic successes are clearly defined.

"Shock Therapy in Psychiatry"

A Manual

By: Lucie Jessner, M. D., Ph. D., Resident Psychiatrist, Baldpate, Georgetown, Mass.; Graduate Assistant in Psychiatry, Massachusetts General Hospital; Assistant in Psychiatry, Beth Israel Hospital, Boston; and V. Gerard Ryan, M. D., Associate Psychiatrist, Elmcrest Manor, Portland, Conn.; Assistant in Psychiatry, Harvard Medical School.

Introduction by Harry C. Solomon, M. D., Clinical Professor of Psychiatry, Harvard Medical School; Chief of Therapeutic Research, Boston Psychopathic Hospital.

Published by Grune & Stratton, Inc., New York, 1941. Price, $3.50.

This monograph is presented as a brief, practicable review of the three generally accepted methods of "Shock Therapy" as applied to the treatment of schizophrenia; namely, insulin, metrazol, and electrically produced convulsions. It should be of value to the psychiatrist, the pathologist and the medical scientist who wishes to inform himself concerning the benevolent as well as the malevolent results of the methods of treatment of some psychoses with convulsions produced by insulin, metrazol or electricity.

"Synopsis of the Preparation and Aftercare of Surgical Patients"

By: Hugh C. Illgenfritz, A. B., M. D., Instructor in Surgery, Louisiana State University School of Medicine; Visiting Surgeon, Charity Hospital of Louisiana at New Orleans; and Rawley M. Penick, Jr., Ph. B., M. D., F. A. C. S.

With Foreword by Urban Maes, M. D., D. Sc., F. A. C. S., Professor of Surgery and Director of the Department, Louisiana State University School of Medicine; Senior Visiting Surgeon, Charity Hospital of Louisiana at New Orleans; Consulting Surgeon, Touro Infirmary.

Published by The C. V. Mosby Company, St. Louis, 1941. Price, $5.00.

The Mosby Synoptic Series is progressing steadily. In this volume the authors offer a practicable guide for the care of surgical patients during their stay at the hospital and the course of treatment to which they are subjected. The book's usefulness to surgical residents and surgical practitioners is further increased by detailed description of the pathogenesis of each of the various complications as well as by outlining the physiologic basis for each therapeutic measure recommended. Many recently advocated therapeutic procedures have been outlined briefly.

"The Art and Science of Nutrition"

A Textbook on the Theory and Application of Nutrition

By: Estelle E. Hawley, Ph. D.; and Grace Carden, B. S., the University of Rochester, School of Medicine and Dentistry, Rochester, N. Y.

With 180 Illustrations, including 12 in color.

Published by The C. V. Mosby Company, St. Louis, 1941. Price, $3.50.

This book has grown out of the authors' realization of the paramount need for scientific knowledge of food and its use, of metabolic needs in health and disease, and the art of modifying the diet of normally living man to his best advantage. The doctor, the nurse, the housewife, all, will find within the pages of this book much valuable information in relation to food and feeding. With better selection of food products made possible by our modern methods of collection, preparation, preservation and transportation, it remains necessary for the nurse or homemaker to present the food in an attractive and palatable manner. How this can be best accomplished is interestingly told by the authors of this work. Since they believe that the theory of nutrition is learned best in a course of lectures, such a course is outlined in full detail.

"Professional Adjustment—I"

By: Gene Harrison, A. B., R. N., Educational Director, Druid City Hospital School of Nursing, Tuscaloosa, Alabama.

Published by The C. V. Mosby Company, St. Louis, 1941. Price, $2.25.

Professional Adjustment I is designed for use for freshman students, while Professional Adjustment II, to be published soon, is to be used by the junior and senior classes of schools for nursing. Since much of the nurse's and the patient's success depends upon sympathetic and intelligent understanding of the patient as a total personality, as a human being sick with a disease, living under certain conditions in a certain environment, she must learn to qualify herself physically, psychically and spiritually to take charge of the patient's needs and to fortify herself against unethical or unprofessional conduct. The nurse of the present and the future must aspire to satisfy high professional standards, unimpeachable personal conduct, and must be able to radiate positive, constructive, artful and scientific sympathy for all types of human beings so that she may successfully promote health, happiness and well being in the community which she is called upon to serve. These two books are expected to correctly guide the student nurse along accepted lines of procedure.

"Synopsis of Genitourinary Diseases"

By: Austin I. Dodson, M. D., F. A. C. S., Richmond, Virginia; Professor of Genitourinary Surgery, Medical College of Virginia; Genitourinary Surgeon of the Hospital Division, Medical College of Virginia; Genitourinary Surgeon to Crippled Children's Hospital; Urologist to St. Elizabeth's Hospital; Urologist to St. Luke's Hospital and McGuire Clinic.

Third Edition.

With 112 Illustrations.

Published by The C. V. Mosby Company, St. Louis, 1941. Price, $3.50.

In order to keep this synopsis strictly up to date, the author found it necessary to issue this new edition. In it are incorporated the most recently discovered and developed chemotherapeutic agents, especially those of the sulfanilamide group, which have completely and beneficially revolutionized the therapy of genito-urinary tract and allied infections and diseases.

Index to Advertisers

Borden Company, The	XI
Camel Cigarettes	VII
Children's Hospital, The	XIII
Coca-Cola	V
Frye Company, Geo. C.	XIII
Gay Private Hospital	XV
Holland-Rantos Co., Inc.	VI
Hospital Pharmacy, Inc.	XIII
Hynson, Westcott & Dunning, Inc.	XIV
Jones' Private Sanitarium	XV
Leighton's Hospital, Dr.	XV
Lilly & Company, Eli	XII
Mead Johnson & Company	XVII
Medical Auditing Counsel	XIV
Parke, Davis & Company	X
Petrogalar	XVI
Philip Morris & Co.	VIII
Physicians Casualty Association	XIV
Prentiss Loring, Son & Co.	XIII
S. M. A. Corporation	II
State Street Hospital	XV
Upjohn Company, The	III
Winthrop Chemical Co., Inc.	IX
Zemmer Company, The	20

Patronize Your Advertisers

The Journal
of the
Maine Medical Association

Volume Thirty-four Portland, Maine, February 1943 No. 2

*State Responsibility for Tuberculosis Control**

By Alton S. Pope, M. D., Boston, Massachusetts
Massachusetts Department of Public Health

The control of diseases dangerous to the public health is a primary function of health departments, both state and local. The division of responsibility between state and community, however, varies with the political philosophy of the state in question. In Massachusetts, where local autonomy is indigenous, the State Department of Public Health is given only advisory powers in relation to the cities and towns and only in the presence of an epidemic can it assume powers coördinate with the local boards of health in the control of communicable diseases. Was it perhaps as a final gesture of independence of parental authority that Maine endowed its State Department of Health with supervisory power over the functions of the local boards of health? The point is now largely academic but it has probably had an influence on administrative practice in tuberculosis control in this state.

Because the hereditary theory of the etiology of tuberculosis continued to influence medical as well as lay opinion for many years after the discovery of the tubercle bacillus, health departments were slow in accepting any responsibility for the control of tuberculosis. The first sanatoria were private institutions, designed purely for treatment, and nearly two decades passed before the medical or health authorities took any active steps to deal with tuberculosis as a communicable disease. The possibilities of prevention were generally obscured by the stigma that has dogged tuberculosis through the centuries. Maine can claim the honor of being the second state to make tuberculosis a reportable disease by act of its Legislature in 1895. Biggs, however, through his report to the New York City Board of Health in 1893, is generally credited with laying the foundations of effective preventive work, when for the first time he secured the compulsory reporting of known cases of tuberculosis in that city.

Even before the reporting of cases was generally required the success of sanatorium treatment at Saranac Lake and elsewhere had encouraged several states to embark on sanatorium programs. Massachusetts led the way with the opening of the Rutland State Sanatorium in 1898. The establishment of this institution was epoch-making, both in demonstrating the practicability of bringing

* Read before the meeting of the Maine Medical Association at Poland Spring, Maine, June 22, 1942.

the sanatorium within reach of the patient and in its recognition of the principle that treatment of the indigent tuberculosis patient is the responsibility of the community.

Rutland, like most of the early public sanatoria, was built and operated by the state under a board of trustees. For fifteen years the state assumed full responsibility for tuberculosis control and continued to build sanatoria in different areas where they were needed. As the demands for hospitalization grew, however, the legislature became panicky at the magnitude of the problem it had assumed and attempted to divide the responsibility by passing an Act requiring all counties and cities of 50,000, or over, to construct their own sanatoria. At the same time a degree of state control was retained by the Subsidy Act, which authorized the State Department of Public Health to pay a subsidy of $5.00 per week to any city or town hospitalizing a tuberculosis patient in a sanatorium approved by the Department. Not until 1919 was the operation of Massachusetts state sanatoria transferred to the State Department of Health. In retrospect, Massachusetts could have provided better sanatorium service at less cost by continuing the construction of state institutions when and where needed, instead of requiring counties and large cities to build sanatoria for their local needs.

Although all state health departments now participate to some extent in the program for tuberculosis control, Mountin[1] has pointed out that the form of participation varies widely and in only one-quarter of the instances is the state department the only agency concerned. In a number of states tuberculosis commissions or boards of control still direct most administrative functions except reporting. Other official state agencies participating actively in the program include boards of welfare, departments of education, and state universities. These various agencies, except tuberculosis commissions and boards of control, as a rule contribute some special service in line with their regular function.

In Colorado the state has no sanatoria of its own and provides hospital care entirely by subsidizing a number of the excellent private sanatoria that were vacated by the depression and by the tendency of other states to build their own institutions where they are more accessible to the patients. Other variations in the pattern of control include the construction and operation of sanatoria by voluntary associations on a fee basis, and the administration of all diagnostic and educational as well as hospital functions by the state sanatorium. The form of organization is not in itself so important as is its adaptability to the local problems of tuberculosis control.

To measure the state responsibility in this field it is necessary to outline briefly the accepted content of a tuberculosis program, and then to consider how the respective needs can be most effectively met.

The diversity of ways in which states provide sanatorium facilities has already been discussed and the advantages of central control have been emphasized. A complement which should be added to sanatorium care is adequate provision for pneumothorax refills after the patient has returned to his home. Where distances are not too great periodic return to the out-patient department of the sanatorium is ideal. In more remote areas reciprocal arrangements with other state or county sanatoria offers a satisfactory solution, but the responsibility of the parent institution for making such an arrangement must be recognized.

Reporting of cases, as previously noted, in a number of states lagged behind provision for sanatorium care. This was due in part to a dread of the disease which made patients unwilling to accept the diagnosis, in part to carelessness on the part of physicians and perhaps more than anything else to a feeling that reporting contributed nothing to the cure of the patient or the control of the disease. States with good reporting have from 2-2.5 reported cases per annual death yet the average for the country is only 1.6 cases per death and eight states still report less than 1 case per death.

Case reporting is of necessity a joint function of physicians, local board of health and state department. The local case register is more important than the state list for control purposes, but the state can and should assist the local boards in setting up a proper register and in supplying information on patients

who have died or moved out of the community.

Diagnosis is the starting point of most forms of communicable disease control and in tuberculosis presents special difficulties. So long as physical examination was the main dependence it could be provided adequately by the private practitioner and the local board of health. Laboratory diagnosis called for more specialized training and except in larger cities and in sanatoria is most satisfactorily furnished by state laboratories.

Recognition of the indispensable role of the X-ray has done more than any one thing to make the early diagnosis of tuberculosis possible, but the cost of roentgenography has until very recently seriously retarded its application. The cost of equipment and the requirement of skilled interpretation limits the use of this method to large clinics or hospital units, yet only when the roentgenogram is as freely available to the physician as is laboratory examination of sputum will it be possible to find any large proportion of cases in an early stage.

In a number of states X-ray diagnostic service is now built around the state or county sanatoria. Patients unable to go to a private radiologist are referred by their physician to the out-patient department of the sanatorium and the report of the examination, including the roentgenogram, is made directly to the referring physician. All family contacts of patients admitted to the sanatorium are likewise examined as soon as possible after admission. In areas too large to be conveniently served by the sanatorium direct, periodic clinics staffed by the sanatorium can be held in the out-patient department of a local hospital or in the board of health quarters. Other states have provided diagnostic service through mobile clinics, utilizing portable X-ray apparatus and local nursing services.

Mass examinations of industrial workers, people on welfare rolls or other groups subject to a high incidence of tuberculosis and the examination of high school or college students are case-finding procedures that offer the greatest opportunity for finding truly incipient tuberculosis and, except in the large cities, are most effectively and economically carried on by the state agency.

Law enforcement and the promulgation of rules and regulations are in most states central rather than local functions. In tuberculosis control these measures are more often educational than coercive. A few states have enacted statutes for the forcible hospitalization of recalcitrant patients. Theoretically, it is good practice to remove such individuals who will not voluntarily take precautions to limit the spread of their own infection. Practically, it has usually resulted in the repeated hospitalization of a few individuals, who are in most instances soon released on habeas corpus, and in serious disciplinary problems in the institutions where they are hospitalized. Unquestionably the fear engendered by the procedure has kept large numbers of other patients from seeking medical advice and has thus delayed diagnosis.

Much can be accomplished by uniform and well-drawn rules and regulations and in states where the state department has no legal jurisdiction over the towns such recommended regulations can profitably be adopted by the communities. Boards of health in small towns cannot be expected to have the technical training necessary for the preparation of effective sanitary codes or rules for nursing supervision and the preparation of such outlines by the state agency is a productive form of promotional service.

Education of the public in the essentials of tuberculosis control has from the beginning been one of the main objectives of the National Tuberculosis Association and its branch organizations. Much of the success of our tuberculosis program today is unquestionably due to the vision of those pioneers who nearly forty years ago saw the indispensable role of informed public opinion in securing the application of established scientific principles. That need will continue so long as tuberculosis is a public health problem and its place should be recognized by physicians and laymen alike. The special opportunity of the official state agencies lies in providing scientific guidance for the development of a sound educational program by the state and county tuberculosis associations. In many states such a liaison is effected by

the inclusion of one or more state or county tuberculosis officers in the board of directors of the voluntary association.

Another field in which tuberculosis associations have profitably supplemented the work of state agencies is the demonstration of new procedures which call for practical trial before they can be incorporated in the official program. Rehabilitation is now generally accepted as a practical way of meeting the problem of readjustment for the recovered patient who finds that physical limitation prevents his return to his former job. In many instances limited basic education or lack of any technical training makes any specific job training slow and expensive. To be effective re-education of the patient must begin during the course of treatment and the primary responsibility should rest with the sanatorium staff. The special techniques of aptitude testing and vocational guidance have their place, but unless the physical capacity of the patient has been accurately estimated by his physician and the program of re-training wisely subordinated to treatment the end results of rehabilitation will be disappointing. With proper guidance and adequate support from state or county authorities no measure gives greater opportunity for further reducing the waste from tuberculosis.

One of the most important functions which a state or municipal health department can perform is the elaboration of sound methods of public health practice. Twenty-five years before Koch's epochal discovery, William Budd[2] had on the basis of his own observations worked out the essential facts in the epidemiology of tuberculosis. The prevention of tuberculosis since that time has been ineffective not so much from lack of knowledge of the disease as from inability to apply it. The effectiveness of a control method must in the last analysis be tested under field conditions and here the State or large city health department has an opportunity as well as a responsibility.

Fifteen years ago it was postulated that the discovery and treatment of primary tuberculosis in children would prevent a large proportion of phthisis. Ten years of exacting work and the expenditure of hundreds of thousands of dollars were required to prove that this was not the hoped-for short-cut to the goal of tuberculosis control. Yet only by such experience could the facts be obtained, and through the widespread contacts which the testing involved was gained a popular understanding of the tuberculosis problem which has proved invaluable in the general campaign.

Routine examination of family contacts, the most productive method of early case-finding yet involved, is definitely a product of large scale testing of an epidemiological hypothesis. It was not enough to know that 4 to 8 per cent of contacts had X-ray evidence of significant tuberculosis; years of further observation were necessary to determine that the yield of active disease between the ages of 3 and 12 is insignificant and that grandparents are frequent but unsuspected sources of infection.

One of the most serious obstacles to routine contact examination has been the high cost of roentgenography and it took the critical work of such groups as Horton and his associates[3] and of Seideman[4] to show that 95 per cent of all pulmonary tuberculosis found in clinic patients is diagnosed at the first examination and that among contacts re-examined at regular intervals the great majority of new cases develop within the first two years. Application of these simple facts in clinic practice will result in an annual saving of many thousands of dollars.

Progress in our knowledge of the tubercle bacillus and in the development of diagnostic methods has been the result of numberless studies by bacteriologists, chemists, physicists and clinicians. Successful application of these methods and the possibility of the ultimate eradication of tuberculosis are likely to rest upon the coördinated efforts of state and municipal health agencies.

Summary

1. Responsibility for the control of tuberculosis is of necessity divided between state and local health authorities.
2. Such functions as the construction and operation of sanatoria, the operation of

Continued on page 35

*The Use of an Out-Patient Department in the Control of Tuberculosis**

By David Daniels, M. D., Western Maine Sanatorium, Greenwood Mountain, Maine

The year 1929 was the first year of service in the Out-patient Department of the Western Maine Sanatorium.

As time progressed and the Out-patient Department grew, it was evident that the best opportunity for prevention and early diagnosis of tuberculosis in adults was to discover and eliminate advanced tuberculosis. Because many people are usually in the advanced stages of tuberculosis and are seriously ill before consulting their physician, it was most logical to turn to the private physician and ask his participation in the importance of case finding and preventive medicine.

In 1941, the private physicians were asked to refer any patients with evidence of any pathologic condition of the chest that otherwise could not be definitely diagnosed, and patients in whom they suspected tuberculosis, as well as apparently healthy individuals in whom it was desirable to rule out the disease. The Out-patient Department placed at the disposal of the private practitioner certain services necessary for the diagnosis and control of tuberculosis which were not at his immediate command, and which the patient could receive, whether or not he were able to pay the fee. The patient's ability to pay, and if so, how much, whether the patient received town aid, etc., is determined by the referring physician. Only patients who present a letter from a private physician are admitted. It is not necessary for the practitioner to write or telephone for an appointment as there are regular hours and days for the examination of out-patients. On Tuesdays from 3.00 to 5.00 P. M., and on Fridays and Sundays from 9.00 A. M. to 11.00 A. M., and from 3.00 P. M. to 5.00 P. M.

The fees for those who are able to pay is from $2.00 to $10.00 for both examination and X-ray, or for just an X-ray. For patients receiving town aid, the town of settlement is billed at the flat rate of $2.00.

School children reactors are X-rayed without charge if unable to pay the minimum fee.

Every patient is told that the fee charged is a State fee, and that it is sent in its entirety to the State Treasurer. A receipt is given to every patient who pays.

Unless a thorough history and chest examination are requested, only an X-ray film is taken.

A complete report to the referring physician is made of the following: The physical findings (if an examination is specified), an X-ray report of the diagnosis, or a discussion of the differential diagnosis, the opinion of the consultant as to the proper procedure of treatment, and further disposition of the case, with practical suggestions as to how this can be best accomplished in the individual instance.

In cases where activity is present, the importance of contact examinations is stressed, and an invitation to have contacts examined and X-rayed is made. The physician is asked to view the X-ray film and to consult about the case if he so desires. Laboratory tests which seem indicated are made.

When the diagnosis is questionable or difficult to make on the initial visit, a request is made for subsequent visits. All such returns are made through the referring physician.

Frequently patients return for periodic examinations, or they are again referred because new developments arise and the case needs further advice.

In the examination of contacts we recommend the following procedure: Children should be skin tested and if the test is positive, X-rayed. With normal X-ray findings, the child is not seen again until the age of twelve when he is again X-rayed and then

* Read before the meeting of the Maine Medical Association at Poland Spring, Maine, June 22, 1942.

followed by yearly X-rays until he has reached the age of thirty.

Those Children who upon initial examination show some form of primary phase of first infection have various recommendations made, ranging from frequent X-ray examinations, restriction of activity, to Sanatorium admission.

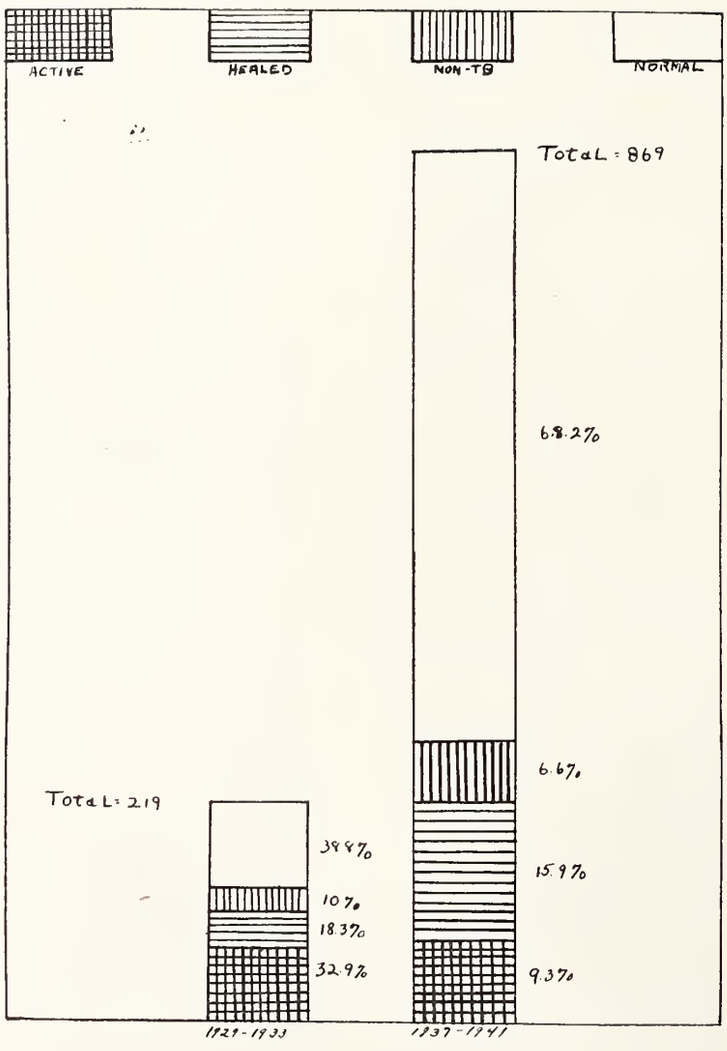
Those Children who have a negative skin test have a second test at the end of a three-month interval and if negative at this time, are followed by yearly skin tests. They are not X-rayed until the skin test becomes positive.

All Adolescents with positive skin tests, and Adult contacts are followed by periodic X-ray examinations. The interval between X-rays varying from three to six months in recent contacts to yearly X-rays in removed contacts. Adolescents in this group are X-rayed until the age of thirty. Adults are X-rayed for several years.

The examination of contacts and of patients referred by private physicians because of suspicious symptoms has yielded many new cases of tuberculosis.

In this study the total number of persons examined is divided into three groups: Contacts, persons with a known history of exposure to an open case of tuberculosis, Symptoms, persons who gave no history of known contact with an open case, but who were referred because of suspicious symptoms, and Survey, or persons who were examined because of positive skin reactions.

Chart No. 1

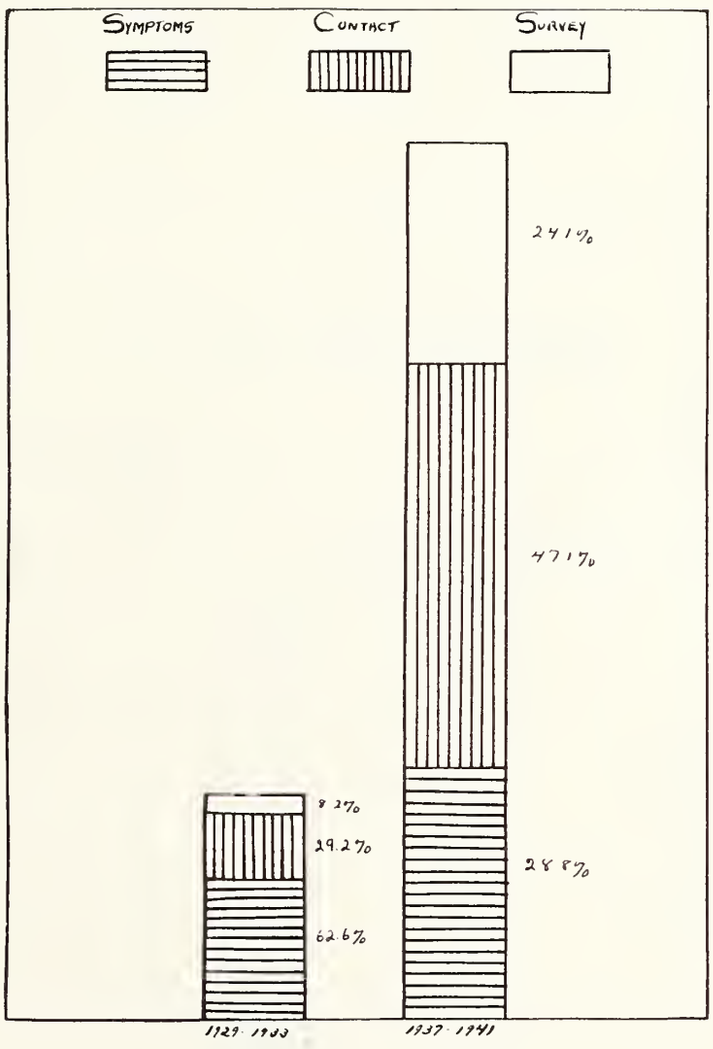


Comparative analysis of diagnosed cases for five-year periods, 1927-1933, inclusive, and 1937-1941, inclusive.

Chart No. 1 shows the number of new patients and their diagnoses for both five-year periods. During the first five-year period, 1929-1933, inclusive, 219 new patients were examined, 32.9% (72) of whom had active pulmonary tuberculosis, 18.3% (40) had healed tuberculosis, 10% (22) had non-tuberculous pulmonary pathology such as: Bronchitis, pneumonitis, emphysema, bronchiectasis, lung abscesses, neoplasms, and congestive heart failure, and 38.8% (85) had normal chest findings.

During the next five-year period of this study, from 1937-1941, inclusive, 869 new patients were examined, 9.3% (81) of whom had active pulmonary tuberculosis, 15.9% (138) had healed tuberculosis, 6.6% (57) had non-tuberculous pathology, and 68.2% (593) had normal chest findings.

Chart No. 2



Comparative analysis of reasons for examination of out-patients in the two five-year periods, 1927-1933, inclusive, and 1937-1941, inclusive.

In chart No. 2, we have tabulated the reasons for examinations of patients for both five-year groups. Of the 219 patients in the first group, 62.6% (137) were examined because of symptoms, 29.2% (64) because of contacts, 8.2% (18) because of survey.

Of the total of 869 new patients in the second group, 28.8% (250) were examined because of symptoms, 47.1% (409) because of contact, and 24.1% (210) because of survey.

Coincidental with the vast increase in the

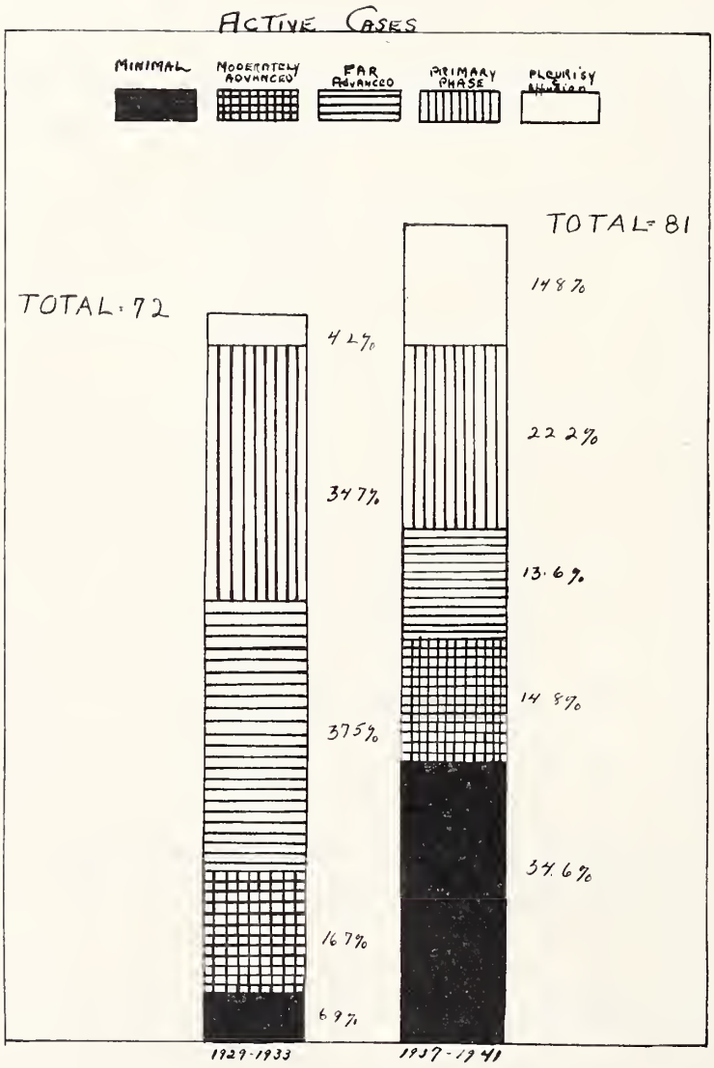
number of patients examined, the percentage of the number of active cases discovered decreased from 32.9% to 9.3%. This implies that the more people examined, the less tuberculosis was found but in actual figures, an increase of 9 additional cases over that in the 1929-1933 period was found.

Reviewing chart No. 1, the question might arise as to whether or not it was of value to examine so many more patients merely to find only an additional 9 active cases of tuberculosis.

Since patients with minimal amounts of disease may be considered as probably non-infectious while patients with moderately advanced disease as possibly infectious, and patients with far advanced disease as almost certainly infectious, we feel that it was worth while. As chart No. 3 shows, the percentage of minimal cases increased from 6.9% to 34.6% (in other words, the number of minimal cases increased from 5 for the first five-year period to 28 in the second five-year period).

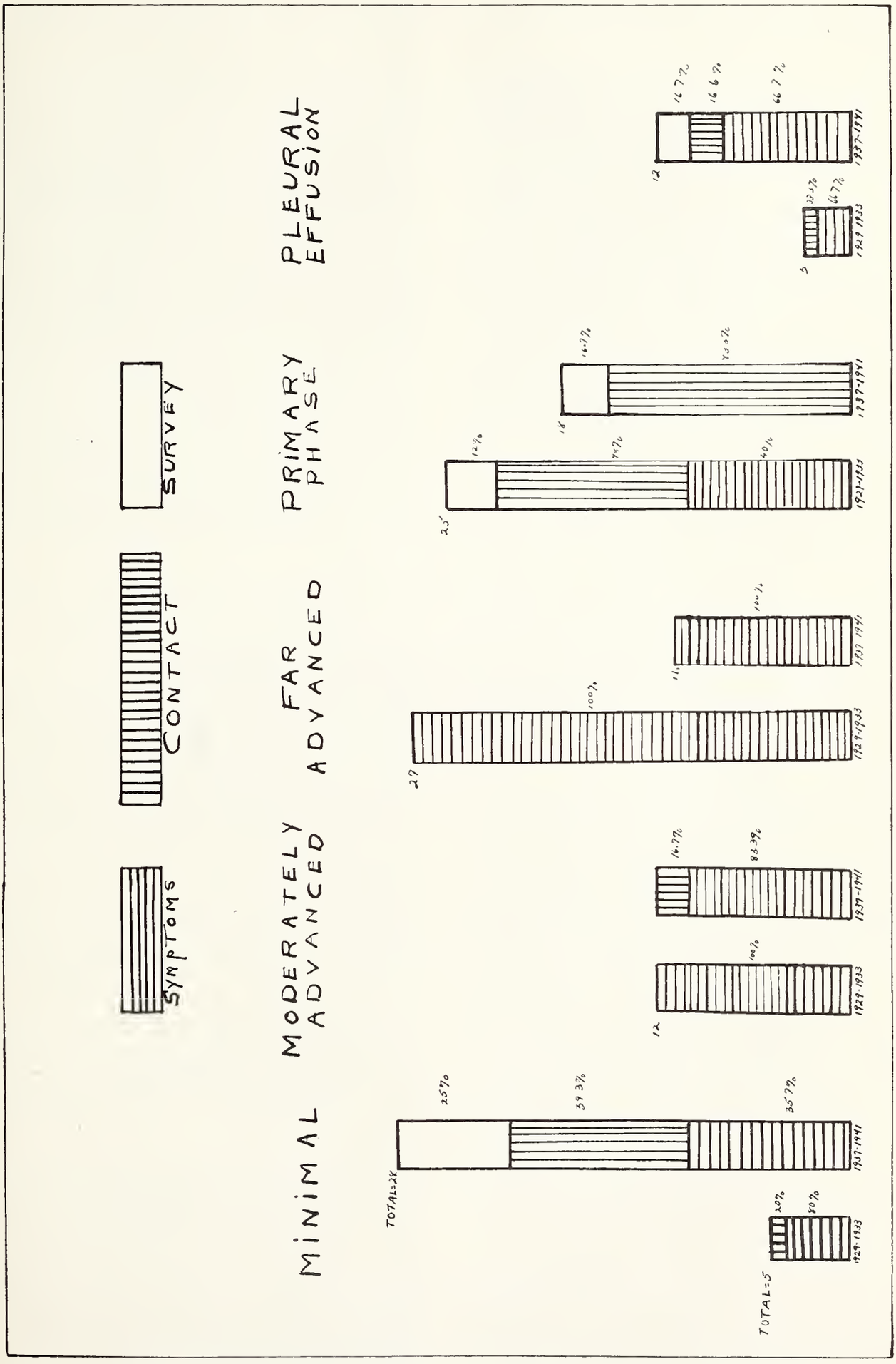
From chart No. 4 which shows the reasons why the patients with active tuberculosis were referred to the Out-patient Department, we see that in the first five-year period, 80% (4) of the minimal cases came because of symptoms, and 20% (1) came as a result of contact whereas in the second five-year group, 35.7% (10) came because of symptoms, 39.7% (11) because of contact, and 25% (7) came because of survey. (In other words al-

Chart No. 3



National Tuberculosis Association classification of active cases diagnosed in the five-year periods, 1927-1933, inclusive, and 1937-1941, inclusive.

CHART No. 4



Comparative analysis of reasons for examination of active cases in both five-year periods.

though only 1 case of the minimal cases in the first five-year period was symptom free, 18 in the second five-year period were symptom free; this increase occurring in a group which is considered probably non-infectious and in whom the process of arrest of the disease and rehabilitation is far more certain, less time consuming and less expensive.)

In chart No. 3, the number of moderately advanced cases remained the same in both groups 16.7% (12) of all active cases in the first period and 14.8% (12) in the second period. The only difference noted in this group of possibly infectious cases was that in the second period, as chart No. 4 shows, we obtained 16.7% (2) who were symptom free.

Moreover in the first five-year period, chart No. 3, a total of 37.5% (27) of the total active cases were far advanced, whereas in the second five-year period a total of only 13.6% (11) were far advanced. In both groups, as chart No. 4 shows, all the far advanced cases were seen because of symptoms. We feel, however, that we have made considerable progress since the percentage of far advanced cases is decreasing, lessening the possibility of infecting others, decreasing the costs of caring for the very ill patients, and permitting us to admit to the Sanatorium a larger number of minimal and moderately advanced cases for adequate treatment.

During the first five-year period, chart No. 3, 34.7% (25) of the total number of active cases were diagnosed as Primary phase or Childhood tuberculosis, and during the second-year period 22.2% (18) of the total number of active cases were similarly diagnosed. Chart No. 4 shows 40% (10) of those in the first five-year period were referred because of symptoms, 48% (12) because of contact, and 12% (3) because of survey. Of the group in the second five-year period none were referred because of symptoms but 83.3% (15) came because of contact, and 16.7% (3) because of survey. We diagnosed a smaller number of primary phase disease in the second five-year period, chart No. 3, but all these were diagnosed before symptoms appeared.

In chart No. 3 the first five-year period shows 4.2% (3) of the active cases diagnosed as tuberculosis pleurisy with effusion, whereas in the second five-year period 14.8% (12) of the active cases were similarly diagnosed. 66.7% (2) of those in the first period, on chart No. 4, had symptoms, and 33.3% (1) was a contact. 66.7% (8) of those cases in the second period had symptoms, 16.6% (2) were contacts, and 16.6% (2) were the result of survey.

Because our experience with in-patients has demonstrated that a certain percentage of patients with an active primary phase or with pleurisy with effusion will in a variable number of years develop advanced pulmonary disease, we consider these phases of active tuberculosis as significant. Patients exhibiting these forms of the disease are, like minimal cases, considered probably non-infectious. If these are included we find that in the first five-year period a total of 45.8% (6.9% Minimal, plus 34.7% Primary phase, plus 4.2% Pleurisy with effusion) were probably non-infectious. 16.7% were possibly infectious and 37.5% were almost certainly infectious.

In the second five-year period, a total of 71.7% (34.6% Minimal, plus 22.2% Primary phase, plus 14.8% Pleurisy with effusion) were non-infectious, 14.8% were possibly infectious and 13.6% were almost certainly infectious. In other words the percentage of non-infectious disease increased 25.8%. (From 45.8% to 71.6%). The percentage of possibly infectious disease decreased 1.9% (from 16.7% to 14.8%), and the infectious decreased 13.9% (from 37.5% to 13.6%).

The number of non-infectious cases increased 25 (from 33 to 58) while the number of almost certainly infectious cases decreased 16 (from 27 to 11).

The increase of non-infectious cases and the decrease in almost certainly infectious cases has been accomplished by the widespread examination of contacts and through surveys.

As the Out-patient Department has grown we have seen an increasing number of healed cases of tuberculosis. In the first five-year period 40 patients were diagnosed as healed and in the second five-year period 138 diagnosed as healed. For these patients various recommendations are made, varying from a second examination at a short interval to periodic examinations.

Conclusions

1. The procedure followed in the Out-patient Department of the Western Maine Sanatorium has been outlined.
2. Through coöperation and interest of private physicians, the number of patients seen has increased from 219 for the first five-year period, 1929-1933, inclusive, to 869 in the second five-year period, 1937-1941, inclusive. The percentage of patients seen because of symptoms decreased from 62.6% in the first period to 28.8% in the second period. The percentage of symptom-free cases increased from 37.4% in the first five-year period to 71.2% in the second five-year period. Simultaneously with the increase in the percentage of symptom-free cases, there has been an increase in the diagnosis of favorable cases of tuberculosis of 25.8% and a decrease in the diagnosis of advanced, or unfavorable cases of 13.9%.

Aims

To establish appropriate relationships with practicing physicians which offers the best means of exploring the most fertile areas for the discovery of tuberculosis in its earliest stages.

We would like to bring under medical observation and treatment tuberculous people who are unaware and unsuspecting of having the disease thus finding the disease in the incipient stages.

Treating the patient whose symptoms lead him to seek medical care does not help in the control of the disease except in isolating him, but diagnosing minimal cases who have no symptoms and preventing their progression to an advanced stage, which is the most important source of infection, would in a sense be preventing tuberculosis.

State Responsibility for Tuberculosis Control—Continued from page 28

diagnostic and refill clinics and other procedures that require trained personnel and expensive equipment are more efficiently and more economically operated on the state than on the local level.

3. State laws should provide for the hospitalization of all patients in need of sanatorium care, regardless of their ability to pay. Charges for such care are best divided between the town of residence and the state.
4. For the sake of uniformity it is desirable that rules and regulations be promulgated by state rather than local health departments.
5. Education of the public in the principles of tuberculosis control can well be delegated to the voluntary associations, with scientific guidance from the state health department.
6. Control practices must keep pace with our growing knowledge of tuberculosis, and it is a primary responsibility of state health departments to develop more economical as well as more effective methods of tuberculosis prevention.
7. Because the control of tuberculosis necessarily involves the patient, the physician, the local and state health departments, the effectiveness of a state program is measured by its success in coördinating the efforts of these various agencies concerned quite as much as by its provision of direct services.

1. Mountin, J. W., and Flook, E.: Distribution of health services in the structure of state government, Chapter III, Tuberculosis control by state agencies. *U. S. P. H. S. Reports*, 57:65-90, Jan. 16, 1942.
2. Budd, W.: Memorandum on the nature and mode of spread of phthisis. *Lancet* (London), 2:451-452, Oct. 12, 1867.
3. Horton, R., Lincoln, N. S., Deegan, J. K., and Dalton, M.: Productive and non-productive examinations in tuberculosis case finding. By courtesy of the authors.
4. Seideman, R. M.: Unpublished data, by courtesy of the author.

Editorials

Status of Maine Medical Association Membership

The following chart, a duplicate of that used in the Maine Medical Association office, shows the membership status of the Association as of January 23, 1943. As changes in membership are reported to this office they are noted on our roster, and the figures on this chart adjusted accordingly.

Lists of Members in Military Service have been published in the last five issues of the Journal and will be continued as long as new names are reported to this office. If you are in the service and your name has not appeared on any of these lists, or if you know of some member of the Maine Medical Association in Military Service whose name has not been included, please notify us at once and help us keep our roster and Journal mailing list up to date.

County	Active Members	Honorary	In Military Service	Total
Androscoggin	55		16	71
Aroostook	36	3	4	43
Cumberland	127	9	45	181
Franklin	11	1	5	17
Hancock	14	1	8	23
Kennebec	65		24	89
Knox	20	1	7	28
Lincoln-Sagadahoc	22	2	3	27
Oxford	33	2	7	42
Penobscot	76	1	16	93
Piscataquis	9	2	6	17
Somerset	18	2	4	24
Waldo	7	1	3	11
Washington	15	4	3	22
York	42	2	9	53
Totals	550	31	160	741

Physicians Needed as Replacements in Civilian Service

Three hundred and five older physicians already have been voluntarily relocated to new areas as a part of their contribution to the war effort, but opportunities still remain for service in critical areas, boom towns and large industrial organizations in the replacement of physicians who have gone or who are willing to go into the armed forces, *The Journal of the American Medical Association* points out in its January 9 issue. *The Journal* says:

"Every physician may well take pride in the manner in which the medical profession has responded to the nation's call for service. More than one month ahead of schedule the medical profession voluntarily met the procurement objectives (quotas) of the Army and Navy. The response to calls for service continues; through the Procurement and Assignment Service carefully considered scientific planning of future procurement objectives has been formulated. The willingness of physicians to enlist before quotas were established greatly reduced the number of remaining physicians in some areas. Already three hundred and five older physicians have

been voluntarily relocated to new areas as a part of their contribution to the war effort. Opportunities still remain for service in critical areas, boom towns and large industrial organizations in the replacement of those physicians who have gone or who are willing to go into the armed forces. Younger physicians, those under 37 years of age who are physically disqualified for the armed services, are urgently needed. Total war means total effort of every individual for victory. Physically disqualified physicians under 37 years of age may be most effective in the war effort by offering their services to the Procurement and Assignment Service. The state committee of the Procurement and Assignment Service in each state will discuss the arrangements and opportunities for this service with those who volunteer."

48 American Physicians Died in Military Service During 1942

The annual summary of deaths among physicians as compiled by *The Journal of the American Medical Association* and published in the January 16th issue of that publication states that 48 American physicians died in Military Service during 1942, from the following causes:

"Eleven physicians died in action during World War II and 37 while in military service. Of those killed in action, 4 died in the Philippine Islands, 1 at Corregidor, 1 when a ship in the Carribean was torpedoed, 1 somewhere in the Pacific, 1 at Java, 1 at sea (unknown) and 2 at Guadalcanal. Of those who died while in military service, 9 were killed in airplane accidents and 3 were reported suicides. Coronary diseases were responsible for 7 deaths, acute epidemic hepatitis 1, septicemia 1, carcinoma of the sigmoid 1, and uremia 1. Two died when the barracks were destroyed by fire and 1 was killed by the accidental discharge of a sentry's gun, 1 in a shipwreck off the coast of Newfoundland, 2 in automobile accidents and 1 in a train accident. The rest were classified under various physical conditions."

Maternal and Child Welfare

The Newborn

(Continued from the January, 1943, Issue of the Journal, *Page 16)*

The care of the newborn's skin is too important to leave to the nurse or grandmother, as that tissue is easily infected and is sensitive to trauma. Water and soap should not be used nor should strenuous efforts be made to remove the vernix caseosa. All too frequently we find a nurse scrubbing industriously with gauze in the axilla or groin. She is almost sure to remove some of the top layer of skin along with the vernix. Don't let her do it.

Various oils have been recommended for the newborn skin. All are better than water, but any of them, especially those containing antiseptics, will irritate some skins. If they are used, they should be applied with the bare hand and not with gauze. Ammoniated mercury ointment in strengths of from two to five percent has been used with the idea of preventing impetigo. Five percent is definitely too strong, and two percent has been shown to cause casts and blood cells to appear

in the urine. The author of this article has tried it and given it up because of too frequent skin irritations.

This author believes that the best treatment of the newborn's skin is no treatment at all. Leave it entirely alone, except for the diaper area. Remove no vernix. Apply nothing. Give no bath. Put the infant in cotton underwear. The vernix will disappear in twenty-four to forty-eight hours. The skin will not be irritated and the baby will smell sweet and clean. The first bath is given in ten days or two weeks. Since using this method the writer has had no trouble. Occasionally the skin becomes a little too dry. One or two applications of boric acid ointment will relieve the dryness.

The newborn is given sterile water every three hours. No sugar is added lest a fermental diarrhoea be started. He is put to the breast as soon as the mother is rested and three times daily thereafter until the milk comes in. Five minutes is long enough for these early feedings. A longer time tires the baby and irritates the mother's nipples to no good end. When the milk flow is established, the three- or four-hour schedule may be used as best fits the individual case. Do not be afraid to abandon the fashionable four-hour schedule. It does not always work. On the four-hour schedule it is better to use both sides each time, as eight hours is too long between emptyings of the breast.

Reams of paper have been covered with writings on the cause and prevention of the initial weight loss. Your author can see no reason for excitement. If nature had felt worried about it, she would have caused the breast milk to come in at once instead of waiting three days. She gives the little stranger a good panniculus adiposus to cover the initial period of inanition so that the gastrointestinal tract may have time to take up its function. Water must be provided but attempts to prevent the initial weight loss by early strong feeding are apt to result in needless trouble.

The newborn should have at least one good physical examination before discharge. A good nurse will report to the physician about the vigor of the cry, ability to nurse, movements of extremities, color, stools, etc., but an inexperienced lay attendant will have to be told what to look for. Nothing should be taken for granted. The examination is done with the baby unclothed, but precautions should be taken against chilling. The technique is essentially that used for an adult but a few special points will be mentioned.

Inspection yields considerable information. Nutrition may be noted as good, fair, or poor. A well nourished infant has enough subcutaneous fat to conceal the ribs. Maturity may be judged roughly by the weight and length. The lower limits are five and a half pounds and eighteen and three-quarters inches in length.

The activity of the baby gives important information. The normal resting attitude is one of moderate flexion. Flaccidity is abnormal. While crying the legs and arms are doubled up, the fists clenched, and the eyes closed tightly. Failure in any of these items suggests fracture, dislocation, or paralysis. Sneezing is frequent and does not mean that the infant has caught cold. Continued failure to nurse suggests intracranial trauma. The cry of the premature is high pitched and that of the cretin is hoarse. A piercing cry occurring during sleep suggests increased intracranial pressure.

There are a few points in the topical examination that are worth mentioning. The circumference of the head is greater by about two cm. than that of the chest. A bulging fontanelle indicates hemorrhage, a sunken one, dehydration. A considerable growth of coarse hair suggests cretinism. When the eyes oscillate or rotate blindness is possible. White circumscribed elevations along the median raphe of the palate and at the gums should not be touched.

Respirations are usually rapid and irregular but should be effortless. If exceptionally shallow, suspect atelectasis. The abdomen of the full-term infant is prominent, and more so in prematures. The liver is normally palpable about two fingers' breadth below the costal margin but the spleen should not be felt.

The conventional reflexes in the newborn are not of great importance except for confirming impressions. There is one which is

Continued on page 43

COUNTY SOCIETIES

Androscoggin
President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Thomas G. Harvey, M. D., Mars Hill
Secretary, Clyde I. Swett, M. D., Island Falls

Cumberland
President, Roland B. Moore, M. D., Portland
Secretary, Eugene E. O'Donnell, M. D., Portland

Franklin
President, James W. Reed, M. D., Farmington
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Charles C. Morrison, M. D., Bar Harbor
Secretary, Edward Thegen, M. D., Bucksport

Kennebec
President, Adolphe J. Gingras, M. D., Augusta
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Abbott J. Fuller, M. D., Pemaquid

Lincoln-Sagadahoc
President, Edwin M. Fuller, Jr., M. D., Bath
Secretary, Jacob Smith, M. D., Bath

Oxford
President, Lester Adams, M. D., Greenwood Mt.
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Ernest T. Young, M. D., Millinocket
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Cardy, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Maurice S. Philbrick, M. D., Skowhegan
Secretary, Maurice E. Lord, M. D., Skowhegan

Waldo
President, Lester R. Nesbitt, M. D., Bucksport
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Perley J. Mundie, M. D., Calais
Secretary, James C. Bates, M. D., Eastport

York
President, Arthur J. Stimpson, M. D., Kennebunk
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Paid-Up Membership for 1943

Piscataquis County Medical Society

Knox

DECEMBER 15, 1942

The annual meeting of the Knox County Medical Society was held on Tuesday, December 15th, at Rockland, Maine.

The secretary's report was read and accepted. It was voted that the Society go on record as approving the work of the National Physician's Committee and that a sum of money be sent the committee to aid in their work.

Officers for the ensuing year were elected as follows:

President, Herman J. Weisman, M. D., Rockland.
Vice President, Saul R. Polisner, M. D., Camden.
Secretary-Treasurer, Abbott J. Fuller, M. D., Pemaquid.

Delegates to the Maine Medical Association, C. Harold Jameson, M. D., Rockland, and James Carswell, Jr., M. D., Camden.

Alternates, Drs. Weisman and Fuller.

Censors, Alvin W. Foss, M. D., Rockland (1944); Gilmore W. Soule, M. D., Rockland (1945); and Dr. Carswell (1946).

Programs for coming meetings were discussed and arrangements made for same.

A. J. Fuller, M. D.,
Secretary.

JANUARY 19, 1943

The regular meeting of the Knox County Medical Society was held on Tuesday, January 19th, at Rockland, Maine.

An invitation from E. C. Higgins, M. D., Lewiston, Secretary pro-tem of the Androscoggin County Medical Association, to meet them in a joint session on January 21st was read and discussed. Owing to the traveling conditions and sickness, it was decided that it was not advisable to make plans for all members of the Society to attend but that the individual members should go if possible.

James Carswell, Jr., M. D., of Camden, lectured on *Evaluation of Commercial Preparations Used in Endocrinology.* Treatment by the available commercial preparations was discussed followed by a great deal of general discussion which seemed to indicate that as yet no completely standardized treatment with the endocrine products is firmly established. It was felt that the proprietary names are often confusing.

A. J. Fuller, M. D.,
Secretary.

Penobscot

The regular meeting of the Penobscot County Medical Association was held on Tuesday, January 19, 1943, at the Bangor House, Bangor, Maine.

At the business meeting, Leon S. Lippincott,

M. D., was elected to membership by transfer from the Issaquana-Sharkey-Warren Counties Medical Society, Mississippi. Doctor Lippincott is a former Maine man having graduated from Bowdoin College in 1913. For the past 23 years he has been a Pathologist in Vicksburg, Mississippi. He comes to Bangor to take charge of the Pathological Laboratory at the Eastern Maine General Hospital, relieving Herbert E. Thompson, M. D., who, because of illness has been appointed consulting Pathologist.

At the scientific session an unusually interesting presentation, *Problems in Hematology*, was given by William Dameshek, M. D., of Boston.

There were fifty-four present.

FORREST B. AMES, M. D.,
Secretary.

York

The Annual Meeting of the York County Medical Society was held January 13, 1943, at the York Hospital, York Village, Maine. Dinner was served at 1.00 P. M., followed by the meeting and program.

The officers elected for the year 1943 are:

President, Arthur J. Stimpson, Kennebunk; Vice President, Waldron L. Morse, Springvale; Secretary-Treasurer, C. W. Kinghorn, Kittery.

Board of Censors: J. R. LaRochelle, Biddeford; J. H. MacDonald. Kennebunk; Pliny A. Allen, York Harbor.

Delegates to the Maine Medical Association Annual Meeting: Edward M. Cook, York Harbor; James H. MacDonald, Kennebunk; C. W. Kinghorn, Kittery.

Alternates: Gerald R. Smith, Ogunquit; William H. Kelly, Sanford.

Committee on Resolutions: David E. Dolloff, Biddeford; Gerald R. Smith, Ogunquit; Edward M. Cook, York Harbor.

It was voted to hold the next meeting in April, at Biddeford, with Drs. Dolloff and Roussin in charge of the program.

All other meetings for the year will be subject to call by the Executive Board.

Respectfully submitted,
C. W. KINGHORN, M. D.,
Secretary.

New Members

Penobscot

Leon S. Lippincott, M. D., 489 State Street, Bangor, Maine.

Change of Address

Oxford

Smalley, Fred L.

From: Bryant Pond, Maine

To: Lebanon, New Hampshire

Doctor Smalley is taking over the practice of Walter A. Rihl, M. D., of Lebanon, "for the duration," thereby allowing him to enter Military Service.

Members in Military Service

Androscoggin

Brooks, Glidden L.,	Lewiston
Harkins, Michael J.,	Lewiston
Tousignant, Camille,	Lewiston
Viles, Wallace E.,	Turner

Cumberland

Hebb, Henry S.,	Bridgton

Knox

Dennison, Frederick C.,	Thomaston

Oxford

Bean, Johnson L.,	Norway

A Doctor's Plea in Wartime

The doctor's life, in times like these,
Is not exactly one of ease.

For on the home front, each M. D.
Is busier than any bee!

He's shouldering the burden for
The other docs, who've gone to war.

This leaves your doctor precious little
Time to sit around and whittle.

And indicates the reason why
You ought to help the poor old guy.

How?

1. By keeping yourselves in the best of condition
   Thus avoiding the ills that demand a physician.
2. By phoning him promptly when illness gives warning,
   But—unless very serious—waiting till morning.
3. By cheerfully taking whatever appointment
   He makes for prescribing his pills or his ointment.
4. By calling on him where he works or resides
   Instead of insisting he rush to your sides.

   (Of course, he'll come 'round when there's need for his service
   But spare him the trip when you're nothing but nervous.)
5. And last but not least, you can help in this crisis
   By carefully following Doctor's advices.

If these commandments you'll adhere to
A doctor's heart you will be dear to!

Have You Paid Your 1943 State and County Dues?

Book Reviews

"Communicable Disease Nursing"

By: Theresa I. Lynch, R. N., Ed. D., Instructor in Education, New York University; Formerly Superintendent of Nurses and Director of Instruction, The Willard Parker Hospital, New York City.

With 156 Text Illustrations and 5 color plates.

Published by The C. V. Mosby Company, St. Louis, 1942. Price, $3.75.

This book presents the subject of Communicable Disease Nursing as it is taught in modern hospitals and practiced in the home and the hospital, and shows the part the nurse may play in the community. The information given is comprehensive, clear and readily available for immediate use in time of specific need.

Military Medical Manuals—Manual of Dermatology

Issued under the Auspices of the Committee on Medicine of the Division of Medical Sciences of the National Research Council by Donald M. Pillsbury, M. D.; Marion B. Sulzberger, M. D.; Clarence S. Livingood, M. D. 421 pages with 109 illustrations.

Published by W. B. Saunders Company, Philadelphia and London, 1942. Price, $2.00.

This is a condensed manual on dermatology for use in the military service. The latest military figures of the U. S. Army (1940) indicate that skin diseases produced 9.8 percent of all admissions to the sick list. This book sets forth briefly and simply the management of dermatoses encountered in the armed forces, and is a valuable compend on the principles of diagnosis and treatment of the more common skin diseases.

"Surgery of the Ambulatory Patient"

By: L. Kraeer Ferguson, A. B., M. D., F. A. C. S., Lieut. Commander, Medical Corps, United States Naval Reserve; Assistant Professor of Surgery, University of Pennsylvania; Surgeon, Philadelphia General Hospital and Doctor's Hospital, etc., etc.

With a Section on Fractures by Louis Kaplan, A. B., M. D., F. A. C. S., Associate in Surgery, University of Pennsylvania; Associate in Surgery, Mt. Sinai Hospital, etc.

645 Illustrations.

Published by J. B. Lippincott Company, Philadelphia, London, Montreal, 1942. Price, $10.00.

The patient suffering from minor defects which can be treated, removed or corrected most usually visits the factory clinic, the municipal clinic or the general practitioner. In almost every case the treatment is provided by a young physician or one not readily in a position to avail himself of the various conveniences of a well equipped hospital service. The book under review is presented to the profession with the aim in view to provide the practitioner with instruction in surgery for minor

defects which may be treated while the patient remains ambulant. The field is very well covered and the type of treatment recommended is usually the kind which has been actually performed by the author and found most satisfactory.

"Management of the Sick Infant and Child"

By: Langley Porter, B. S., M. D., M. R. C. S. (Eng.), L. R. C. P. (Lond.), Dean Emeritus, University of California Medical School and Professor of Medicine, etc., etc., and William E. Carter, M. D., Director of University of California Hospital, Out-Patient Department, etc.

Sixth Revised Edition.

Published by The C. V. Mosby Company, St. Louis, 1942. Price, $11.50.

The fundamental advances made during the past few years by physicists, physiologists, biochemists, immunologists, pathologists and pharmacologists made necessary the incorporation of the results of their work in a new and revised issue of this very well liked textbook. The authors have tried to satisfy the needs of all those physicians who are responsible for the successful management of the care of sick infants and children and having tried hard they have succeeded well in their newest effort.

"The Modern Attack on Tuberculosis"

By: Henry D. Chadwick, M. D., Superintendent of Westfield State Sanatorium, 1909-1929, etc., and Alton S. Pope, M. D., Chief, Bureau of Communicable Diseases, Department of Health, Chicago, etc.

Published by The Commonwealth Fund, New York, 1942. Price, $1.00.

The authors discuss the current problems in tuberculosis control from the standpoint of health officers, public health nurses and those whose duty it is to deal with community health in general as well as in particular in the hope of reducing and finally eradicating this feared disease.

"Physician's Reference Book of Emergency Medical Service"

A Compilation, Chiefly from Medical Literature, Presenting the Practical Experience and Lessons Acquired in Handling Civilian War Casualties

Published by E. R. Squibb & Sons, New York, 1942.

The subject matter is compiled chiefly from British and some American medical literature and deals with civilian accident medical practice as modified by total war injuries, such as crush, blast, bomb and burn injuries, shock, etc., as encountered during air raids.

Maternal and Child Welfare—Continued from page 38

peculiar to the newborn and is constant, the Moro embrace reflex. It is elicited by forcibly striking the table on which the baby lies, by suddenly lowering it a short distance, or by startling it with a loud noise. Normally the arms are thrown out, after which they are brought toward each other in a jerky manner. The hands are fanned out first and then clenched tightly. Asymmetry of response indicates injury of the inactive side. Absence of the reflex indicates intracranial damage.

The presence of light perception can usually be determined. Normally the infant will close his eyes when a bright light is shone upon them. Presence of the light reflex indicates light perception. Hearing is more difficult to detect. Usually, however, the infant who hears blinks his eyes at a loud noise.

We plan to submit later an article on infant feeding but a few general remarks will not be out of place here. The best food, of course, is breast milk and no mother should be permitted to deny this to her infant for a whim. However, no infant should be "starved to the breast." Failing breast milk, boiled cow's milk or evaporated milk with one of the usual carbohydrates added make an acceptable substitute. The various ready-to-use foods are by no means universally satisfactory and tend to encourage laxity on the part of the physician.

There is no harm in giving the newborn time to adjust himself to his food. A moderate amount of spitting up is not abnormal. Loose stools with some undigested particles are not uncommon in the first few days. Neither symptom requires a change of formula if the baby is contented and doing well otherwise. It is not wise to struggle too hard for weight gain in the early days. Many infants are poor eaters at first and some do not gain for a time in spite of apparently adequate food intake. If the physical examination is normal, these babies will usually straighten out if left to themselves.

Your Committee on Maternal and Child Welfare.

Index to Advertisers

Blackwell, Elmer N.	XVII
Borden Company, The	VI
Brewing Industry Foundation	III
Camel Cigarettes	XIV-XV
Children's Hospital, The	XVII
Coca-Cola	XVIII
Corn Products Refining Co.	VII
Crane Discount Corporation	XVII
Frye Company, Geo. C.	XVIII
Gay Private Hospital	XIX
Holland-Rantos Co., Inc.	XI
Hood's	VIII
Hospital Pharmacy, Inc.	XVII
Jones' Private Sanitarium	XIX
Leighton's Hospital, Dr.	XIX
Lilly & Company, Eli	XVI
Maine Surgical Supply Co.	43
Martin's	42
Mead Johnson & Company	XXI
Medical Auditing Counsel	41
Oakhurst Dairy	
Parke, Davis & Company	1
Petrogalar	
Philip Morris & Co.	XI
Physicians Casualty Association	XVI
Prentiss Loring, Son & Co.	XV
State Street Hospital	XI
Squibb & Son, E. R.	XII
Wine Advisory Board	VI
Winthrop Chemical Co., Inc.	X
Wyeth & Brother Inc., John	XX
Zemmer Company, The	41

Patronize Your Advertisers

The Journal
of the
Maine Medical Association

Volume Thirty-four Portland, Maine, March, 1943 No. 3

*Epidemic Meningitis**

Cerebrospinal Fever

Spotted Fever

Roscoe L. Mitchell, M. D., Director of Health,
State of Maine, Department of Health and Welfare, Augusta, Maine

This disease occurs both in localized epidemics and sporadically.

Cerebrospinal fever — caused by the meningococcus, should be sharply differentiated from other forms of cerebrospinal meningitis which may be caused by a great variety of organisms, such as bacillus tuberculosis, pneumococcus, streptococcus, influenza bacillus, colon bacillus, typhoid bacillus, and others not so common. Patterson, in Manchester, England, recently reported 2 cases caused by paratyphoid B organism. Both recovered after sulfapyridine therapy. The gonococcus may cause meningitis as a complication.

The epidemic form of meningitis, however, is always caused by some one or other of the types of the meningococcus.

The first recognized epidemic outbreak of cerebrospinal fever occurred in Geneva in 1805, and was followed by a similar outbreak in Massachusetts in 1806. Since that time there have been numerous epidemics, one in Grenoble, France, in 1814. There is no record of the disease between 1816 and 1822, when it reappeared in France among soldiers.

It was known in Italy in 1839 to 1845; Algiers, 1839 to 1847; Gibraltar, 1844; Denmark, 1845 to 1848; mild form in England, 1848; malignant in Sweden in 1854; and before 1870 it had visited the other European countries.

Again in the United States, 1822-23, it appeared at Middletown, Connecticut, and has prevailed more or less in all the states since 1842. There was a particularly severe outbreak beginning in Philadelphia in 1863. Stille and Pepper recorded 2,575 deaths from 1863 to 1891 in Philadelphia alone.

In New York the winter of 1904-05, 6,755 cases were reported with 3,455 deaths. This epidemic was a part of a pandemic which started in Europe and spread over the whole world. Following this pandemic, the disease became comparatively quiescent until stirred to renewed activity by the World War I.

Subsequent to 1924, the general trend of occurrence of the disease was upward for the

*Read before a meeting of the Cumberland County Medical Association, at Portland, Maine, January 13, 1943.

country as a whole until 1930, since when there was a general decline in epidemics.

In 1939, there were 1,962 cases reported; in 1940, 1,667 cases; in 1941, 2,023 cases; and for the first 49 weeks of 1942, there were 3,387 cases reported in the whole country.

In Maine the trend has been variable since 1932 when 13 cases were reported. 1933—11; 1934—10; 1935—7; 1936—19; 1937—18; 1938—10; 1939—10; 1940—16; 1941—12; 1942 to December 26—125.

Forty-seven of the 125 cases have been reported from Portland. The remaining 78 have been pretty much scattered, cases having been reported from every county except Lincoln and Franklin, representing 48 towns and cities.

Places reporting more than one case are: Auburn, 2; Lewiston, 7; Caribou, 2; Fort Fairfield, 2; Presque Isle, 2; Freeport, 3; Scarboro, 2; South Portland, 6; Yarmouth, 2; Dixfield, 2; Bangor, 6; Lincoln, 2; Brownville, 2; Liberty, 2; Old Orchard, 2; and, of course, Portland, 47.

Fourteen death reports in all were received up to December 1st. Providing the death certificates are all in, this represents a low death rate.

In Great Britain, cerebrospinal fever has been of epidemic proportions since early 1940, running around 12,000 cases annually. The case fatality there runs about 20%. (See Report, Ministry of Health, October 24, 1942, Lancet, pp. 493.)

Epidemics of this disease usually occur under crowded conditions, as in camps, on shipboard, or in institutions, but may occur anywhere. Wherever large numbers of people live and work in close contact, its spread is favored.

The *seasonal* prevalence of the disease is *marked,* especially in the temperate zone, the largest number of cases occurring during the colder months of fall and winter.

On the other hand, wide spread outbreaks *have* occurred in the tropics. Here in the north, the prevalence corresponds to that of other diseases spread by secretions of the nose and mouth, like pneumonia, scarlet fever, and diphtheria. This is in distinct contrast to the seasonal prevalence of infantile paralysis, which is much more prevalent in the summer and warm fall months.

As to susceptibility, children and young adults are most often attacked. The disease has been called a disease of children and soldiers, and Roseneau† says, "The soldiers who suffer most are those in barracks, camps, and garrisons, rather than those on the march or in the field."

Even so, no large epidemics appear to occur among troops, but the disease is more or less prevalent in all armies.

Fortunately, cerebrospinal fever is not as highly communicable as many of the acute infectious diseases, but spreads slowly and irregularly. Seldom is a case traced directly from one case to another.

The incubation period is variable, and may be as short as one day in children, to 10 to 14 days in adults—commonly 7 days.

The predisposing causes of cerebrospinal fever are generally acknowledged to be crowding, insanitary surroundings, fatigue, catarrhal inflammations, and undernutrition.

Prevention

The measures for control of meningococcus meningitis which have been instituted have not produced results such as to promote much confidence in their efficiency.

Theoretically, control should be easy; practically, it is extremely difficult. The general prevalence of the infectious agent, the large number of carriers, the existence of mild and abortive cases, all add to the complexity of the matter of administrative control of the disease.

It was found by Gordon and others in Boston in 1917 that 1% of persons who had no known contact with a case, were carriers of the disease, and up to 80% among persons who had been intimately exposed under military conditions. Most of these carriers proved to be temporary, no meningococci being found after a month or two.

Roseneau, in his latest edition of "Preventive Medicine and Hygiene," says: "We must frankly admit that when cerebrospinal meningitis has once become epidemic it can-

† Milton, J., "Preventive Medicine and Hygiene."

not be stamped out by any known means of practical application."

I do not believe that we should take the truth of this statement entirely for granted and junk all attempts at control.

It is evident that isolation of persons ill of the disease is important because it reduces the number of carriers. But to search out and isolate all contacts does not appear to be justified because of the general prevalence of the infection and the long period of isolation necessary before the organism disappears from the nasopharynx, and the comparatively few cases which develop among exposed persons and carriers. No local or other treatment yet devised has any influence on the carrier state.

It appears futile to quarantine casual contacts of cases of meningitis in view of the large number of people who are actual carriers, who have not been in contact with a known case. Smillie says that for every known contact isolated, there are 8 or 10 unknown carriers still at large. The large amount of time loss by isolation of such contacts hardly seems justified, considering the slight incidence of the disease among them.

We have mentioned crowding and undernutrition as predisposing causes of meningitis.

Of course, *crowding* is the main facilitator in the spread of so called "Droplet Infections" or respiratory diseases, of which cerebrospinal fever is one.

The British Ministry of Health says: "Quite apart from other inconveniences of droplet spread diseases, they cause an enormous interference with the war effort."

Adequate housing for workers and proper spacing of cots in barracks should have a beneficial effect in controlling the spread of all respiratory infections, including meningitis.

In 1918, Glover *(Journal of Hygiene)* reported that as a result of spacing cots under army conditions, the carrier rate for meningococcus was reduced from an average of 29% to 4%.

It is well known that coughing or sneezing may project infectious material to from 9 to 12 feet or more, and it would seem that to cough or sneeze without the nose and mouth protected by the handkerchief should be made a more serious grade of misdemeanor than spitting in public places.

In justification, it must be acknowledged that the material ejected by a cough or sneeze is fresh and most highly infectious, while the sputum deposited on the ground or floors must undergo cooling, drying, and many times sunlight, all of which tend to reduce virulency; this in spite of the repulsive and disgusting features of promiscuous spitting.

Environmental sanitation and hygiene alone, however, are not sufficiently preventive without measures looking to building up of bodily resistance.

It is acknowledged that meningitis, pneumonia, and some other diseases, attack the apparently robust and pass by others who are seemingly not in the peak of condition. Yet the apparently robust may be suffering from endocrine inbalance or other unknown biological defect, temporarily or otherwise, or from nutritional defects not apparent to the eye.

Malnutrition as a predisposing cause of various infectious diseases is receiving apparently deserved attention since research concerning vitamin content of foods has supplied much basic knowledge not previously available.

The canteen, the school lunch, the "drink more milk" and the meat campaigns have all contributed to popular education in this subject, as did also the nutrition conference called in Washington in May, 1941.

After the outbreak of the war in 1939 it became evident to the British that war could no longer be left to the army and the ordinance plants. Successful war called for the use of every worker and every resource of the community. It was a war of production — of production to keep the *community strong* as well as to furnish weapons to the armed forces. This lesson was quickly learned by the British, and their programs of public health and nutrition were greatly expanded at the same time that the military situation was most desperate.

While in this country an educational pro-

gram is under way, it is becoming realized that talk and pamphlets have not supplied all our workers with an adequate diet.

While the Washington Nutrition Conference of 1941 was initiated from Great Britain's action, we have not followed through to the extent which that country has. There, the Ministry of Food decreed that there should be a canteen in every plant employing 250 or more workers, and the results are summed up in a statment by Sir John Boyd Orr.

He said, "The improvement of the diet of workmen, whose diet was not previously up to the standard for health, is followed by increased output without any conscious increased effort, and also by a reduction in the number of accidents."

No one at the present time knows how much of the distress and absenteeism from work, because of common ailments, would be corrected by proper food; but we do know that good health cannot be maintained without an adequate diet.

Ivy stated in the *J. A. M. A.*, February, 1942, that work demands rest, good food, and wholesome recreation, if physical fitness is to be maintained.

The army recognized this fact, and if the workers on the home front are to produce what it takes to supply the army, they should have equal consideration given to their nutritional status.

To summarize: The *prevention* of cerebrospinal fever at present depends upon general measures which have up to now failed to control epidemics.

The best practice, recommended by persons of experience, consists in:

1. Isolation of patients with the disease.
2. Avoidance of crowding, especially for workers and soldiers.
3. Extension of protecting coughs and sneezes with a handkerchief.
4. Cleanliness of eating and drinking utensils.
5. Maintaining health status by proper personal hygiene, adequate diet, and a reasonable amount of sleep.
6. In furtherance of the idea of accomplishment of better personal hygiene: industrial plants are urged to install adequate safe drinking, toilet, and washing facilities in all plants, including individual towels and drinking fountains or paper cups.
7. Last, but not least, the public should seek medical advice early in all cases where there is headache with chills, fever, and perhaps vomiting; because early treatment offers the best hope of saving lives in this serious disease.

Abstract

From "Delay in the Treatment of Cancer"

Charles R. Harms, Jules A. Plaut, and
Ashley W. Oughterson, M. D.,
J. A. M. A., Vol. 121, No. 5,
January 30, 1943

Summary

"1. Delay in the diagnosis and treatment of cancer is one of the most important factors in the failure to obtain better results by the methods of treatment now available.

2. The patient is responsible for the major part of this delay both in numbers and in the time consumed.

3. This delay by the patient is chiefly due to lack of information as to early signs and symptoms of cancer.

4. The education of the people on the cancer problem is a mutual responsibility of the public and the medical profession. This educational program is still inadequate and ineffective."

*Meningococcus Meningitis**

(A Simplified Plan for Diagnosis and Treatment in the Home)

Ralf Martin, M. D., Portland, Maine

The State of Maine and, more particularly, the greater Portland area is experiencing an increase in the meningococcus infections of sufficient proportions as to cause emergency measures to be taken. Discouragingly enough, at present we have no efficient means of controlling the spread of this disease, so that importance must be laid on the recognition of early cases and immediate effective therapy.

Meningococcic infection takes many interesting forms. In no other acute disease are the manifestations or course more variable. The meningococcus is one of the common saprophytic organisms of the nasopharynx, and as long as it remains here causes no ill effect. Disease manifests itself when in susceptible individuals invasion takes place with resulting septicemia. At this point any of four things may happen: 1. It may be spontaneously aborted; 2. It may become rapidly fulminating with death in a few hours; 3. The septicemia may become chronic with ill health for weeks; 4. It may localize in the central nervous system, resulting in the dreaded meningitis.

We are concerned more particularly with the last or the ordinary acute meningitic form. The common early manifestations are those of a simple infection of the upper respiratory tract with symptoms of the grippe, and under the present conditions anyone presenting this syndrome, whether he has fever or not, should be suspected of having a meningococcus infection and warned to report immediately any untoward progression of symptoms. The patient or the attendant should be on the alert for, first of all, headache, which is always present in individuals old enough to complain of it. It is often dull in character, usually progressive, and not relieved by the ordinary medications. Next in importance are irritability, nausea and vomiting, fever, chills, petechial rash, stiffness and pain in the neck and back, bulging fontanel, and delirium. None of these symptoms and signs are necessarily diagnostic of meningitis, but in the face of the present emergency meningitis must be ruled out. This can be done only by spinal tap, a relatively simple procedure, readily done in the home. All that is necessary are a hypodermic syringe and an ampul of novocaine, a sterile lumbar puncture needle, and two or three sterile vials in which to collect the fluid. Normal spinal fluid is as crystal clear as water and if cloudy fluid is obtained, treatment should be started immediately without waiting for the laboratory report.

It is recognized that many practicing physicians are not inclined to do lumbar punctures in the home, so that the various communities might well follow the example of the Cumberland County Medical Society which has developed so-called "diagnostic units" consisting of a physician adept at the procedure with his equipment ready and on call at all times.

Treatment

The treatment is simple and effective and is that of an adequate sulfa drug level in the circulating blood at the earliest possible moment. Occasionally this can be done by the oral route, but most often it is advisable to give the drug parenterally either because time is precious or the patient vomiting or even comatose. Until recently this was troublesome in the home, but there is now on the market sodium sulfadiazine in 10 cc. ampuls of the 25% solution containing 2.5 grams of the drug which when diluted with 40 cc. of distilled water can be given directly into the vein and may be given intramuscu-

* Read before a meeting of the Cumberland County Medical Association, at Portland, Maine, January 13, 1943.

larly undiluted. The best practice with older children or adults is to give one ampul intravenously and one intramuscularly at the start which constitutes an initial dose of 5 grams. Then carry on with one ampul intramuscularly every eight hours until it can be taken by mouth. For infants and small children give 1 grain per pound of body weight for the initial dose, divided between the two routes, followed by one-third this initial dose every eight hours intramuscularly or until it can be taken by mouth.

The necessary equipment can be carried in any physician's bag, and for convenience is here listed:

One 50 cc. syringe

One 10 cc. syringe

10 cc. ampuls of 25% sodium sulfadiazine†

50 cc. ampuls of distilled water††

Appropriate needles for intravenous and intramuscular injections

The actual technique of giving the drug intravenously is first to boil up and assemble the 50 cc. syringe and needle. Break the top of the ampul of sodium sulfadiazine and draw the contents into the syringe. Then break the top of the 50 cc. ampul of distilled water and draw into the syringe 40 cc. Pull a fairly large air bubble into the syringe and rotate it endwise several times so that the mixing is complete. The air bubble may then be expelled and a suitable vein entered in the usual manner. The actual injection should take at least ten minutes, or 5cc. per minute. For the intramuscular route a 10 cc. syringe is used and the 25% solution is given undiluted deep into the body of the gluteus medius muscle at a point midway between the greater trochanter and the iliac crest.

The rationale of this procedure is that the intravenous dose gives an immediate adequate level but is poorly maintained, while the intramuscular is slowly absorbed and its action even more prolonged than when given orally. This allows for greater spacing.

One precaution must be sounded, and that is that one must be sure to give the drug inside the vein when using the intravenous method, and well into the muscle when using the intramuscular method, as in either case it will cause a slough if deposited in the subcutaneous fat.

A final statement of generalizations regarding the treatment may be added, about which there may be some difference of opinion. Most authorities, however, will agree that sulfadiazine is the drug of choice, that sulfa drugs should not be given intraspinally, that repeated spinal punctures are useless and may do harm, and that the use of antisera in combination with sulfa drugs does not decrease the mortality, unless the latter are poorly tolerated.

† †† If difficulty is encountered in securing these products, the writer suggests the following:

10 cc. size in 25% solution sodium sulfadiazine. (Lederle).

50 cc. size ampuls distilled water. (Lilly).

Percentages of Medical Enlistments To Quota 1942

Alabama, 204; Arizona, 156; Arkansas, 122; California, 81; Colorado, 124; Connecticut, 76; Delaware, 152; District of Columbia, 78; Florida, 118; Georgia, 149; Idaho, 162; Illinois, 82; Indiana, 136; Iowa, 116; Kansas, 114; Kentucky, 168; Louisiana, 214; Maine, 128; Maryland, 109; Massachusetts, 78; Michigan, 126; Minnesota, 98; Mississippi, 161; Missouri, 104; Montana, 122; Nebraska, 91; Nevada, 65; New Hampshire, 85; New Jersey, 107; New Mexico, 224; New York, 78; North Carolina, 163; North Dakota, 114; Ohio, 115; Oklahoma, 132; Oregon, 113; Pennsylvania, 93; Rhode Island, 92; South Carolina, 174; South Dakota, 137; Tennessee, 166; Texas, 147; Utah, 111; Vermont, 96; Virginia, 138; Washington, 126; West Virginia, 153; Wisconsin, 85; Wyoming, 158. These figures are as of October 31, 1942.

Eligibility of Patients for Various Cancer Services

By Mortimer Warren, M. D., Portland[1], Forrest B. Ames, M. D., Bangor[2], Herbert R. Kobes, M. D., Augusta[3]

Physicians, their patients, and various other people such as public health nurses and social workers frequently wish to know about the availability of different services which can be used for individuals who have or who feel they may have cancer. In order that physicians may properly advise their patients this discussion will attempt to clarify the various eligibility factors which determine what services can be used by patients and doctors.

At the present time there are six tumor clinics located at the Maine General Hospital in Portland, the Central Maine General Hospital and St. Mary's Hospital in Lewiston, the Thayer and Sisters' Hospitals in Waterville and the Eastern Maine General Hospital in Bangor. The purpose of these clinics is to make available resources for diagnosis of tumors both benign and malignant. Group consultation both to establish diagnosis and recommend treatment is now considered by almost all interested in the care of the cancer patient as an essential before treatment is started. It is the feeling of the tumor clinic directors that the advice of the group at the clinics should be available to all types of patients, both private and free.

All patients in need of the services of the clinics are eligible to be seen there. It is preferable that all patients be referred by physicians with a written statement as to the past history, examination, and treatment. The physician should be specific as to whether he wishes the patient to be seen only for consultation or whether he also wishes the clinic to assume the responsibility for treatment. Obviously if X-ray or radium treatment is advised the clinic resources must usually be utilized for the skill and equipment for such treatment is available to only a limited extent outside of these clinics and in the hospitals where they are located. If the physician feels that the patient can pay in full or part for services which the clinic might render he should make a statement regarding the financial status. The majority of the clinics will recommend and initiate steps toward treatment for cases referred to the clinics unless a statement that the visit is for consultation only is available to the clinic director. After the first visit to the clinic the clinic director gives the findings in writing to the local physician. Further reports depend on the nature and course of the individual case.

Charges to patients vary. Some clinics have a nominal fee per visit and others have none—in all cases ability to pay is taken into consideration for no person who needs the services of the clinic is refused admission. Payment for treatment or diagnostic procedures is also based on the patient's ability to pay. For those who can make no payment two resources are available to clinics and thus to patients. The Cancer Control Division of the State Bureau of Health pays the clinic nominal fees for various laboratory and diagnostic X-ray charges. Hospitalization for treatment can be paid for in part by the State Hospital Aid Fund if the patient is not receiving general relief and is otherwise eligible for the benefits of Hospital Aid.

The Scannell Fund of the Women's Field Army is used to pay for X-ray and radium therapy of patients seen at the tumor clinics. For patients who cannot meet the cost of such treatment the clinics or hospitals apply to the Women's Field Army.

At the end of each quarter the number of patients who qualify (by having a diagnosis of malignancy) is divided into the total amount of money available for the quarter. This determines the rate to be paid per patient (not per treatment unit). Hospitals are

[1] Chairman, Cancer Committee of the Maine Medical Association.

[2] President, The Women's Field Army, Incorporated of Maine.

[3] Director, Division of Medical Services, State Bureau of Health, Department of Health and Welfare.

then paid according to number of eligible cases treated during the quarter. It should be noted that payments by the Women's Field Army are to hospitals, not to individual physicians.

A portion of the State appropriation for Cancer Control is used to make available public health nursing service for cancer patients. The public health nurse may be used in case finding in order to promote early care of those types of malignancy which will respond to treatment. Efforts are being made to promote closer working arrangements between local physicians, public health nurses and the tumor clinics so that a better and more closely coördinated follow-up may be given to patients seeking service or who are already under care. As this service becomes fully developed the tumor clinics will have less difficulty keeping track of all patients. This is of particular value in establishing the status of "cured" cases. More complete follow-up will make it more and more possible to have material available for statistical study of treatment results and other problems which confront tumor clinic physicians.

Advice relative to the use of the various services can be obtained at all times from the local members of the Women's Field Army who in many instances can also offer valuable service, too.

One extensive problem which we h been able to plan for appropriately is the case which does not need hospita but needs more expert care than can b at home. A good many patients need tive treatment and considerable nursi Hospitals dealing with acute medic surgical problems do not wish to un care for such individuals.

Convalescent home or chronic hospit is not generally available. In most in measures must be taken for families vide care at home using their own res Frequently visits by public health nurs aid families by showing methods to pu caring for these difficult nursing pro In some areas where district or comm nurses are available, bedside nursing can be used. The medical professio other interested groups should stud problem to work out a solution.

This brief review reveals that a num services are available to cancer patients interested in and working toward a medical program for such individuals s use all of these resources. When we a the principle that the group gives th care to the patient with cancer we shall long way toward attaining this imp program.

Tuberculosis is a disease that burns itself down but never burns itself out.—R. G. Ferguson, M. D., Canadian Tuber. Assn.

There is one place above all others where we should look for new cases of tuberculosis —among intimate family contacts of active cases. "Every case comes from another." To this may be added: "And every case may lead to another."—*The Crusader,* Dec., 1940.

Surgical collapse measures do not cure tuberculosis; they simply enhance rest treatment and permit patients to be discharged from the sanatorium in better condition and with more assurance that they will remain well and useful citizens.—Chas. K. Petter, M. D., *Contact,* February, 1941.

Hospital life does not protect agains ill ness, and in fact the occurrence of di as such as appendicitis, pneumonia or tub cu losis appears to be more frequent amon in ternes and residents than among a po la tion less intimately associated with dis se —Reginald Fitz, M. D., *Jour. Amer. Med Assn.,* Sept. 27, 1941.

Every tuberculin reactor has tubercu sis lesions in his body; whether they are m ro scopic in size or have become extensive m not be determined by the test. The fact at complete examination of many persons fails to detect the location of lesions does not s credit the tuberculin reaction.—J. A. Myers, M. D., *Amer. Rev. of Tuber.,* Feb., 1941.

Editorials

Roland L. McKay, M. D., Named State Chairman Procurement and Assignment Service

Roland L. McKay, M. D., Augusta, has accepted the appointment of Maine Chairman for physicians in the war procurement and assignment service for physicians, dentists and veterinarians, to succeed John G. Towne, Brig. Gen., M. C., Ret., Waterville. Doctor Towne who resigned as State Chairman of the Procurement and Assignment Service because this federal post and his position as Medical Adviser for Maine Selective Service were incompatible, will continue in the latter service.

Appointment of Doctor McKay was made by Paul V. McNutt, head of the War Manpower Commission.

Doctor McKay, practicing physician and surgeon in Augusta for the last 33 years, a member of the Kennebec County Medical Association, was appointed to the Scientific Committee of the Maine Medical Association at the 1942 annual session.

Maine Physicians and the War Program

Roland L. McKay, M. D., State Chairman, Procurement and Assignment Service, in a recent communication advises us that **the State of Maine exceeded its quota of physicians for the armed forces in 1942,** and will therefore, have no recruiting of physicians for the present. We are indeed proud of the physicians of Maine who have so gallantly answered the call to our Country's service in the present emergency, and are proud to make this fact a matter of permanent record in the pages of The Journal of the Maine Medical Association.

The problem which now faces the physicians of Maine, and which calls for a sacrifice equal to that of entering military service, is that of relocation of physicians from areas where there is an excess of medical practitioners to areas where there is a scarcity of physicians. We are confident, however, that the physicians of Maine will meet this call in the same spirit with which they have met the call to the armed forces.

Following is Doctor McKay's letter dated February 17, 1943:

"Beginning January 15, 1943, a new procedure was put into operation whereby all physicians, dentists and veterinarians applying for a commission in the United States Armed Forces must first be cleared by the State Chairman of the Procurement and Assignment Service as to their availability.

"As soon as they are cleared as to availability their name is sent to the Officer Procurement District Office where application forms and a final type physical examination will be authorized.

"The State of Maine, having contributed more than its quota for 1942, there will be no recruiting of physicians for the present.

However, in the State there are a few areas where there is a scarcity of medical practitioners and in other sections there is an excess of such men, some of them within the draft ages. It is an unwise procedure to draw men from this state and at the same time to make efforts to introduce men from outside the state to relieve this condition.

"Individual doctors within the ages liable for military service who are thought to be suitable for relocation but who are reluctant to agree will be considered essential by the Procurement and Assignment Service if they will agree to relocation. They will be reported non-essential to the State Director of Selective Service if they remain in the area of surplus.

"The requisitioning of quotas from the State of Maine will be dependent upon the number of medical practitioners who can be relocated."

Maternal and Child Welfare

Breast-Feeding

Ask any obstetrician, pediatrician, or general practitioner what is the best food for the young infant and he will instantly answer, "Breast milk". His response will probably be glib, unreflecting, and without conviction. He learned it at medical school. It was the correct answer to a favorite examination question. There was a paragraph about it in the textbook followed by chapters on how to write formulas for those infants whose mothers failed to produce milk or whose milk "disagreed" with them.

The greatest cause for the American mother's failure to produce milk is the American physician's lackadaisical attitude on the breast versus bottle question. This statement is not made arbitrarily but is based on observations made in Scandinavia five years ago.

Norway and Sweden are similar in climate, dietary, and social conditions as well as in the physical characteristics of their peoples. There does not appear to be any reason why Norwegian and Swedish women should differ in their natural ability to suckle their offspring. Yet in Stockholm, out of more than 2,000 women discharged from the largest maternity hospital in 1937, there were only 5 whose records showed failure of lactation. In Norway conditions are much the same as in America. The explanation of the difference seemed to lie entirely in the divergent views of the medical profession in the two countries. In Sweden the pediatricians were dominated by the idea that breast-feeding was imperative for the good of the child. They expressed this idea so strongly that the mother was made to feel that failure to suckle the baby for the first six months of its life amounted almost to infanticide. All other considerations were set in abeyance and plentiful milk was forthcoming. In Norway the dean of pediatrics was an old professor from Germany whose pride was in his intricate formulas. Babies in Norway were bottle-fed as often as in the United States, the cause, "failure of lactation" being as frequently ascribed.

Interestingly enough, while maternal and neonatal mortality were, at that time lower in Norway than anywhere in the world, mortality and morbidity of infants under one year were higher than in Sweden.

These facts lead to obvious conclusions. In Chicago, a few years ago, DeLee demonstrated a startling difference in the mortality and morbidity of thousands of breast- and bottle-fed infants. We all learned the answer to the examination question years ago in medical school, yet most of us go on letting the mother decide whether she will nurse her baby or not according as her fancy dictates. We give her little guidance and that half-heartedly.

Often the mother is first asked, "Are you going to nurse your baby?" by a nurse when she awakens after delivery. The chances are that she will say, "No", whereupon the baby is forthwith placed on the doctor's routine schedule and formula. The momentous question is settled as simply as that. Possibly it may be asked by the doctor at a prenatal visit. It is still up to the mother to decide and the implication is that the choice is of no more importance than that of pink or blue ribbons for the bassinet. She too has somehow gotten wind of the idea that it is "better" — meaning more self-sacrificing, more *motherly* — to nurse her child, but nobody has ever discussed with her the relative advantages and disadvantages in terms of hours of work, dollars and cents of cost and anxiety over a crying and sick infant.

There is no sense in our taking the Swedish viewpoint and trying to make the American mother think she will kill her child if she does not nurse it. There are too many babies in the neighborhood thriving and growing fat on what they get out of bottles. What we should point out, preferably as early as the 7th month of pregnancy, is that there are certain positive advantages connected with

breast feeding over and above the fact that human milk is the natural food for the human infant and superior to any formula however scientifically devised.

The question of time looms large in the mind of the busy young woman of today. We should tell her that bottle-feeding takes more time than breast-feeding because, in addition to the time spent in giving the baby his food, she must allow at least an hour a day for sterilizing equipment, making up the formula, and warming it before each feeding. She is afraid of being "tied down". She should be informed that it is not only possible but advisable to give the baby one bottle a day from the time he is six weeks old. This will permit her to be away from him for eight hours at a stretch, ample time for any social or other activity, and will also make weaning easy when the time comes.

The cost of even the most inexpensive formula is considerable when calculated for six months and that of some proprietary preparations is really exorbitant. Some mothers may be influenced by this factor if it is pointed out to them. Now particularly, when a milk shortage is threatened and when evaporated milk can often be obtained only one can at a time, this inconvenience may have weight.

Many women refuse to nurse their children because of distaste for the "messiness" of the lactating state, fear of leakage onto their clothes, odors of sour milk and the like. They usually do not voice this objection, feeling that it is unworthy the exalted state of motherhood. It can be met if the physician will volunteer the information that a nursing brassiere should be worn which will preserve the contour of the bosom and prevent the discomfort of sagging breasts. A practical and sanitary way to prevent leakage is to cut a kotex in half and insert it over each nipple. It can be changed as often as necessary and is far superior to waterproof shields in the brassiere which crack and retain odors. The type of woman who harbors this objection to nursing usually can be further influenced in the right direction by the knowledge that nursing is conducive to better postpartum involution of the uterus and that she will probably feel better and avoid future "female troubles" if she breast-feeds her child.

At the time that the prenatal "pep talk" on nursing is given the physician should give also specific directions on the care of the nipples, advising that they be bathed daily with soap and water and anointed with lanolin or cocoa butter and gently drawn out if they are flat. This will not only guard against future trouble with cracked nipples but will put the mother in a nursing frame of mind.

With the expectant mother resolved to nurse her child the battle is one-third won, but only one-third. There are still two more skirmishes before the infant is assured his proper nutriment. The nurses and the neighbors have still to be reckoned with.

The first skirmish comes in the first week of the baby's life. Here the attitude and experience of the nurse are all-important. Few indeed are the babies who seize the nipple and start expertly to sucking when first placed at the breast. The majority must be coaxed, cajoled and patiently taught how to draw nutriment from that strange object. The inexperienced mother is in despair. "The baby won't nurse." If the nurse agrees with her all is lost. Most obstetrical nurses are obsessed by desire to see the baby gain. They therefore ply him with 5% glucose or whatever complementary feeding has been prescribed for the days before the milk "comes in". In the mistaken belief that the normal baby is born knowing how to nurse, they carelessly hand him to the mother at four-hour intervals and impatiently collect him again at the end of twenty minutes. The baby finds it easy to suck from the bottle, the mother's breast fails to get the stimulus of vigorous sucking and again the battle is lost.

The physician himself often defeats the cause of breast-feeding by being at once too careless and too dogmatic in his orders. "Four ounces every four hours" may provide adequately for the caloric requirements of an infant who would be decidedly undernourished by "twenty minutes every four hours". The same mother who will struggle for an hour to get the last drop of formula in will watch the clock and return the child to his crib in exactly 20 minutes if the doctor has ordered her to do so. Babies vary in

vigor of nursing and appetite, not only as individuals but at different times of the day. Milk production varies similarly but not always in direct response to the infant's demand.

Anyone who has systematically weighed a baby before and after every feeding for several days has been amazed at the variation in the amount of milk that the same child will obtain at different times of the day, having appeared equally well satisfied at every feeding. The mother may be dripping milk at 6 A. M. and yield only an ounce or two at 6 P. M. These variations are perhaps a wise provision of nature and hurt nobody unless the course of nature is blocked by unwise orders that nursing be done for a stated time and only at one breast at a feeding. Orders for the breast-fed should be flexible. The mother should be taught while in the hospital to watch for signs of satiety. Among these are falling asleep, facial brightening, refusal of the nipple after a period of gradual intermittance in the vigor of nursing, regurgitation. When they appear she should "bubble" the infant and then offer him the other breast and repeat the process. If the other breast is refused or when satiety again occurs she may safely conclude that the baby has had enough whether he has been nursing 15 minutes or 40. Gessell and Ilg, whose *Feeding Behavior of Infants* is the definitive work on the subject, state that both breasts should be offered at every feeding, the initial one being alternated, and that the child should be kept at the breast from 20 to 40 minutes according to the appearance of satiety. If he is still unsatisfied at the end of 40 minutes he should be given complementary formula feeding. If the latter is frequently required the baby should be weighed before and after every feeding for 24 hours and if the milk obtained is consistently under one ounce it may be practical to abandon the breast-feeding effort. If, however, the mother while in the hospital at times produces 3 or more ounces of milk the chances are that she will develop into a "good milker" if she perseveres until the baby is six weeks old, meanwhile keeping up his caloric requirements by the judicious use of complementary feeding. At times it may be wise in these early weeks to have someone other than the mother give the baby a bottle at the 2 A. M. feeding thus allowing her an uninterrupted night rest.

It is evident that a sympathetic nurse who is alive to the importance of breast-feeding is the doctor's indispensable ally in the second stage of the battle. It is therefore well worth his pains to secure her coöperation. This he can usually do if he makes it plain that he is in earnest about the matter and if he takes the trouble to explain the reasons for his belief in its desirability. A lecture to the student nurses will be helpful.

The third skirmish of the breast- versus bottle-battle occurs when the mother goes home from the hospital. She is weak, nervous, and anxious. The baby's cries which have been merged in the anonymity of the nursery are now painfully personal. The neighbors and older female members of her family shake their heads over "the colic" and suggest or declare that her milk does not agree with the baby and that she must "make" the doctor put him on a formula. Again the physician's tact, patience and belief in the superiority of breast-feeding are taxed. It is easy to accede to these demands and write out a formula but if that is all he does the chances are that the colic will get worse instead of better. McNeil states that there is no condition, except a very rare allergy, in the infant which contraindicates breast-feeding and none in the mother except active tuberculosis. Thoughtful discussion with the mother, reminding her of all the points previously mentioned, and of the fact that it is normal for babies to cry a good deal in the first few months of life takes time but it is rewarding.

The diet of the nursing mother is worth discussing with her. Many women think that they must stuff themselves with rich food and drown themselves with milk, denying themselves meanwhile all sorts of favorite foods, drinks and cigarettes. They should be told to eat just the same well-balanced diet that was prescribed during pregnancy and that anything that agrees with them will probably not hurt the babies. A liberal supply of vitamin B both before and after delivery seems to aid lactation.

Your Committee on Maternal and Child Welfare.

Necrologies

Herbert Eldridge Milliken, M. D., 1880-1943

Herbert Eldridge Milliken, M. D., 63, died at Portland, Maine, on Tuesday, February 9, 1943, of heart trouble following an illness of four years.

Born at Surry, Maine, January 25, 1880, son of William Roland and Sarah Elizabeth Phillips Milliken, he was graduated from Bowdoin Medical School in 1901. The following year he was house doctor at the Maine General Hospital at Portland, and after brief service at the Rhode Island State Hospital in Providence practiced in Northeast Harbor one year, and in Waterville from 1903 to 1910. He came to Portland during the latter year and was at the former St. Barnabas Hospital for two years. After a year's special study at Vienna he engaged in practice in Portland, and was also an instructor at the Bowdoin Medical School, until 1918. He was a member of the attending staff of medical service at the Maine General Hospital for many years.

During World War I Doctor Milliken was in charge of the Gastro Enterological service at a base hospital at Camp Dodge, Iowa, later being transferred to Camp Greene, N. C., and assigned to medical service as instructor in physical diagnosis and lecturer during the mobilization period. Ordered overseas August 14, 1918, he served with Base Hospital 54 under Lieut. Col. Thomas J. Burrage of Portland. He was transferred to Unit 8 and made chief of medical service, a position he held until his discharge from the service July 31, 1919. In 1924 when the Maine General Unit, Medical Reserve Corps, was organized, Doctor Milliken was appointed chief of medical service.

Returning to Portland Doctor Milliken resumed his practice, specializing in internal medicine. He continued until he gave up active work about four years ago and returned to Surry, where he had since resided.

He was a member of the American Medical Association, the Maine Medical Association, the Cumberland County Medical Association, the Portland Medical Club, and of the Maine Historical Society.

During his practice in Waterville Doctor Milliken had served as city physician, as secretary of the Waterville Clinical Society, and was for one term president of the Kennebec County Medical Association of which he was then a member.

He is survived by a brother, Howard A. Milliken, M. D., of Hallowell.

Alfred Mitchell, Jr., M. D., 1872-1943

Alfred Mitchell, Jr., M. D., 70, former Portland physician, died at Georgetown, Massachusetts, on Monday, February 8, 1943, of a heart attack. He had been in failing health for several years.

He was born at Brunswick, Maine, December 6, 1872, son of Doctor Alfred Mitchell, earlier well known practitioner and member of the faculty of Bowdoin Medical School, and Abbie Swett Mitchell. He received his general schooling in Brunswick and was graduated from Bowdoin Medical School in 1898.

Doctor Mitchell took a post graduate course at Johns Hopkins University, Baltimore, Maryland, in 1901-02, specializing in urology, and subsequently studied in clinics in Germany. In 1903 he was appointed adjutant surgeon of the Maine General Hospital in Portland, and was later appointed chief of the urological service, serving until 1937, when he retired.

He was on the consulting staffs of the Queen's Hospital, Children's Hospital, and the former St. Barnabas Hospital in Portland; the Bath City Hospital, Bath; the Webber Hospital, Biddeford; St. Marie's Hospital, Lewiston, and the Mary Goodall Hospital, Sanford.

During World War I he served in the Medical Corps as Captain, later being promoted to the rank of Major.

Doctor Mitchell was a member of the American College of Surgeons, the New England Surgical Society, the American Urological Association, the American Medical Association, the Maine Medical Association, the Cumberland County Medical Association, and the Innominate Club.

He is survived by his widow, Mrs. Edith P. Mitchell.

COUNTY SOCIETIES

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President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Thomas G. Harvey, M. D., Mars Hill
Secretary, Clyde I. Swett, M. D., Island Falls

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Secretary, Jacob Smith, M. D., Bath

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York
President, Arthur J. Stimpson, M. D., Kennebunk
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Paid-Up Membership for 1943

Piscataquis County Medical Society

Franklin County Medical Society

Androscoggin

The annual meeting of the Androscoggin County Medical Association was held on Thursday, January 21, 1943, at Lewiston, Maine. Officers for the ensuing year were elected as follows:

President, Daniel F. D. Russell, M. D., Leeds.

Vice-President, Romeo A. Beliveau, M. D., Lewiston.

Secretary-Treasurer, Leroy C. Gross, M. D., Auburn.

Delegates to the Maine Medical Association: R. A. Goodwin, M. D., Auburn; H. L. Gauvreau, M. D., Lewiston, and W. H. Chaffers, M. D., Lewiston.

Board of Censors: W. J. Fahey, M. D., Lewiston; Blinn W. Russell, M. D., Lewiston, and G. H. Rand, M. D., Livermore Falls.

Charles Lund, M. D., and F. H. Lasky Taylor, M. D., of the Boston City Hospital, Boston, presented the paper of the evening entitled, "Treatment of Burns Subsequent to the Cocoanut Grove Fire in Boston."

Franklin

The Franklin County Medical Society held its annual meeting in Farmington, December 6, 1942.

The following officers were elected for 1943:

President, Albion E. Floyd, M. D., New Sharon.

Vice President, Cecil F. Thompson, M. D., Phillips.

Secretary Treasurer, George L. Pratt, M. D., Farmington.

Delegate to the Maine Medical Association, Dr. Pratt. Alternate, Dr. Thompson.

Currier C. Weymouth, M. D., of Farmington, announced the plans for the annual meeting of the Maine Medical Association, for 1943, which met with general approval.

GEORGE L. PRATT, M. D.,
Secretary.

New Members

Androscoggin

Waldo A. Clapp, M. D., 376 Main Street, Lewiston, Maine.

Rudolf Haas, M. D., Central Maine General Hospital, Lewiston, Maine.

Have You Paid Your 1943 State and County Dues?

*Members in Military Service**

Aroostook

Gormley, Eugene G., Houlton

Franklin

Schmidt, Lorrimer M., Strong

Oxford

Cohen, Leon, Fryeburg
Daniels, S. David, Greenwood Mt.
Jackson, Norman M., Andover

* These names of members in military service have been reported to the Journal office since publication of the preceding issue of the Journal, and supplement all lists published under this heading beginning with the September 1942 issue.

Notices

Cancellation 1943 Annual Session The American College of Physicians

The Board of Regents of the American College of Physicians has announced the cancellation of their 1943 Annual Session, which was scheduled to be held in Philadelphia, April 13-16, 1943. This action was taken after thoughtful consideration of all factors involved, including an intimation from the Secretary of War and the Office of Transportation that larger national medical groups should not plan meetings at the time set; a growing difficulty in getting speakers and clinicians of top rank to maintain the usual standards of the program; prospect of greatly reduced attendance, because civilian doctors are faced with too great a burden of teaching and practice already; a decreasing active membership, due to approximately 25% of all doctors being called to active military service. President James E. Paullin announced, however, that all other activities of the College would be pursued with even greater zeal, and that the College would especially promote regional meetings over the country and organize postgraduate seminars in the various military hospitals for doctors in the Armed forces.

American Urological Association $500 Research Prize Not to be Awarded

Miley B. Wesson, M. D., Chairman, Committee on Research American Urological Association, has notified the Journal office that because of existing circumstances plans for the June meeting of the Association in St. Louis have been cancelled, and that, therefore, the $500 Research Prize annually offered by the American Urological Association will not be awarded this year.

American Board of Ophthalmology 1943 Examinations

NEW YORK CITY, June 4th and 5th
CHICAGO, October 8th and 9th

Candidates will be required to appear for examination on two successive days.

PLEASE WRITE AT ONCE FOR FORMAL APPLICATION BLANKS.

Dr. John Green, *Secretary*,
6830 Waterman Avenue,
St. Louis, Mo.

Announcement

Refresher Course in Laryngology, Rhinology and Otology

March 22 to 27, incl., 1943
University of Illinois College of Medicine

To meet the needs of ear, nose and throat specialists who, under existing conditions, are able to devote only a brief period to postgraduate review study, this didactic and clinical course has been arranged. Registration is limited. The fee for the complete course is $50.00. In letter requesting application for registration, state school and year of graduation, also details concerning specialty training and experience.

Address Department of Oto-Laryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago, Illinois.

Bureau of Health

Services for Crippled Children Clinic Schedule

Waterville: *Thayer Hospital*
Thursday, 1.30-3.00 P. M.: December 31, February 25, April 22, June 24, August 26.

Rockland: *Knox County Hospital*
Thursday, 1.30-3.00 P. M.: February 18, May 20, August 19.

Portland: *Children's Hospital*
Monday, 9.00-11.00 A. M.: December 14, January 11, February 8, March 8, April 12, May 4, June 14, July 12, August 9.

Fort Kent: *Normal School*
Tuesday, 9.00-11.00 A. M.: May 11, August 17, November 30.

Houlton: *Aroostook General Hospital*
Tuesday, 9.00-11.00 A. M.: June 29, October 5.

Presque Isle: *Northern Maine Sanatorium*
Wednesday, 9.00-11.00 A. M., 1.00-3.00 P. M.: May 12, June 30, August 18, October 6, December 1.

Lewiston: *Central Maine General Hospital*
Friday, 9.00-11.00 A. M.: December 18, January 22, February 26, March 26, April 23, May 28, June 25, July 23, August 27.

Rumford:* *Rumford Community Hospital*
Wednesday, 1.30-3.00 P. M.: January 20, April 28, July 21.

Machias: *Normal School*
Wednesday, 1.30-3.00 P. M.: January 13, April 14, July 14.

Portland Cardiac: *Children's Hospital*
Tuesday, 9.00-11.00 A. M.: December 8, December 22, January 12, January 26, February 9, February 23, March 9, March 23, April 13, April 27, May 11, May 25, June 8, June 22, July 13, July 27, August 10, August 24.

Lewiston Cardiac: Temporarily discontinued due to War.

* Note change in date of next clinic and the new interval between clinics.

Please destroy previous schedule.

Tumor Clinics

Bangor: *Eastern Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Magnus F. Ridlon, M. D.*

Lewiston: *Central Maine General Hospital*
Tuesday, 10.00 A. M.-12.00 M.
Director, *E. C. Higgins, M. D.*

St. Mary's General Hospital
Wednesday, 4.00 P. M.
Director, *R. A. Beliveau, M. D.*

Portland: *Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Mortimer Warren, M. D.*

Waterville: *Sisters Hospital*
1st & 3rd Thursdays, 10.00 A. M.
Director, *B. O. Goodrich, M. D.*

Thayer Hospital
2nd & 4th Thursdays, 10.00 A. M.
Director, *E. H. Risley, M. D.*

Book Reviews

"The Eye Manifestations of Internal Diseases"

By: I. S. Tassman, M. D., Associate Professor of Ophthalmology, Graduate School of Medicine, University of Pennsylvania, Philadelphia; Attending Surgeon, Wills Hospital, Philadelphia, Pa.

With 201 Illustrations including 19 in color.

Published by The C. V. Mosby Company, St. Louis, 1942. Price, $9.50.

From time to time medical authors of the past have presented in book form more or less reliable information in regard to manifestations of internal disease visible in the eye. The book under review represents a sincere scientific effort to provide detailed description of eye manifestations as they occur in a great variety of diseases in which correlation between the two actually exists.

The first five chapters provide description of the normal structure of the eye, general description of causes of eye manifestations, and structural abnormalities and their manifestations.

The remaining chapters describe manifestations due to congenital and hereditary abnormalities; infections and infectious diseases; virus, fungus, parasitic and focal infections; drug and chemical intoxications; and nearly every disease of the various structural and functional systems where eye manifestations concomitantly occur, and which are of considerable interest to the ophthalmologist as well as to the general practitioner.

New and Nonofficial Remedies, 1942

Containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1942.

Cloth. Price, postpaid, $1.50. Pp. 671 — XCVII, Chicago: American Medical Association, 1942.

Perhaps the most important feature of this new volume of New and Nonofficial Remedies is the radical rearrangement it has undergone, which it is believed will make the contents more accessible and therefore more valuable to the physician or other interested readers.

The Council has admirably performed its annual task of keeping the text abreast with the progress of medicine.

"Nephritis"

By: Leopold Lichtwitz, M. D., Chief of the Medical Division of the Montefiore Hospital; Clinical Professor of Medicine, Columbia University, New York.

Published by Grune & Stratton, New York, 1942. Price, $5.50.

The author of this book writes on the results of a lifelong study of renal pathology at the bedside as well as in the laboratory. It is a new book in the English language and is not to be considered

as a translation of the author's previously published "The Practice of Diseases of the Kidney," which has appeared in three German, four Spanish and one Portuguese editions. It is written in the conviction that the facts here presented in clear language are based upon the most recent research findings.

"A Textbook of Surgery"

By: American Authors.

Edited by: Frederick Christopher, B. S., M. D., F. A. C. S., Associate Professor of Surgery, Northwestern University Medical School; Chief Surgeon, Evanston (Illinois) Hospital.

With 1,538 Illustrations on 771 Figures.

Third Edition, Completely Revised and Reset.

Published by W. B. Saunders Company, Philadelphia and London, 1942. Price, $10.00.

Since the publication of the second edition two highly important subjects have forced increased attention, namely, war injuries and sulfonamide treatment of wound infection. Both receive considerable mention in the present edition. New authors replaced those members of the old staff of writers who passed on. The present text is a marked improvement over previous ones even though they were of the best available at the time of their publication.

"Treatment in General Practice"

By: Harry Beckman, M. D., Professor of Pharmacology, Marquette University School of Medicine, Milwaukee, Wisconsin.

Fourth Edition, Thoroughly Revised.

Published by W. B. Saunders Company, Philadelphia and London, 1942. Price, $10.00.

The author is inspired with the desire to give to the general practitioner therapeutic information which he needs. It is usually reliable and based on actual experience. Many diseases have been included for the first time. Many others have received greater attention. Asiatic cholera, leprosy, plague, trypanosomiasis and some others have been excluded because they are considered to be very well taken care of by authorities and specialists of great experience. Recognizing the bibliographically recorded authorities as the true authors of his book, Dr. Beckman is trying his best to present complex problems clearly and solves them scientifically and practicably.

"Directory of Medical Specialists Certified by American Boards — 1942"

Published for the Advisory Board for Medical Specialties.

By: Columbia University Press, New York, 1942. Price, $7.00.

The Directory of Medical Specialists, though now appearing only in its second edition, is already well known as the official publication of fifteen American Boards certifying in the medical specialties. This present edition has become necessary because since the publication of the 1939 edition, which listed 14,000 diplomates, over 4,000 more specialists have been certified. Each specialty is confined to one section in which each diplomate is listed biographically as well as geographically for quick reference. In addition there is a general alphabetical list of all diplomates.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1941

With the Comments That Have Appeared in "The Journal."

Chicago: American Medical Association, 1942. Price, $1.00.

The Council on Pharmacy and Chemistry recently issued the thirty-third edition of the Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association. This volume contains in compact form the reports of the Council. These may be divided into four classes: reports rejecting products as not being acceptable for inclusion in New and Nonofficial Remedies, reports omitting from New and Nonofficial Remedies products that have previously been accepted, reports on the nomenclature of various substances and reports in which the Council gives decisions of general interest or summarizes the latest scientific knowledge concerning certain topics.

Index to Advertisers

Borden Company, The	XI
Brewing Industry Foundation	VIII
Camel Cigarettes	XIII
Children's Hospital, The	XV
Coca-Cola	XII
Corn Products Refining Co.	III
Frye Company, Geo. C.	XVI
Gay Private Hospital	XVII
Holland-Rantos Co., Inc.	VI
Hospital Pharmacy, Inc.	XV
Hynson, Westcott & Dunning, Inc.	XII
Jones' Private Sanitarium	XVII
Leighton's Hospital, Dr.	XVII
Lilly & Company, Eli	XIV
Mead Johnson & Company	XIX
Medical Auditing Counsel	XVI
Oakhurst Dairy	V
Parke, Davis & Company	X
Philip Morris & Co.	IX
Physicians Casualty Association	XII
Prentiss Loring, Son & Co.	XV
S. M. A. Corporation	XVIII
Service Bindery	XVI
State Street Hospital	XVII
Winthrop Chemical Co., Inc.	VII
Wyeth & Brother Inc., John	II
Zemmer Company, The	XV

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The Journal
of the
Maine Medical Association

Volume Thirty-four Portland, Maine, April, 1943 No. 4

The Significance of the Rh Factor of the Blood

By Joseph E. Porter, M. D.

(From the Departments of Pathology, Maine General Hospital and Maine Eye & Ear Infirmary, Portland, Maine)

One of the most significant contributions to medical knowledge in the past two years was the discovery of the Rh factor of human erythrocytes by Landsteiner and Wiener[1] in 1940. They observed that after rabbits were injected with red cells of Macacus rhesus monkeys, an agglutinin developed in the rabbit serum which not only agglutinated other rhesus red cells, but also possessed the ability of agglutinating about 85% of human erythrocytes. They designated this property as the Rh factor, and those human bloods which were agglutinated were called Rh positive, while those which were not agglutinated were called Rh negative. The Rh factor when present is a property of the red cells, and there has not been recorded to date a case of naturally acquired agglutinins to this antigen (Rh).*

There are two practical applications which are derived from this knowledge: First, it explains certain intragroup hemolytic transfusion reactions,[2] and secondly, it furnishes an adequate basis for an understanding of the etiology and pathogenesis of Erythroblastosis fetalis.[3, 4]

Since the discovery of the isoagglutinins in blood and the subsequent use of donors of the same type, transfusion reactions have been reduced to a minimum. However, severe and even fatal transfusion reactions have occurred from the use of blood from donors of the same type as the patient. A series of these intra-group hemolytic transfusion reactions was reported and explained by Wiener and Peters[2] in 1940 as due to isoimmunization from Rh positive cells. In their first case, a Group O patient, there was no febrile reaction to the first four transfusions of Group O blood, while following the fifth one the patient experienced a severe chill, temperature rose to 104°F., and on the following day there was hemoglobinuria, oliguria, and an icterus index of 19. Despite alkalinization this patient died 4 days later. At autopsy the kidneys presented the picture of a hemolytic transfusion reaction. The crossmatchings

* Case 5 of Diamond showed anti-Rh agglutinins without previously known transfusion. Diamond L. K. Rh Factor, N. E. J. M., 227, No. 23, 857, Dec. 3, 1942.

were reported as showing no clumping after several hours.

Fresh samples of blood from donor and patient confirmed the original report of Group O, but the patient's serum contained an agglutinin which clumped the donor's cells, which was detected by a special technique. Further examination of these bloods revealed that the patient was Group O (Rh—), while the donor was Group O (Rh+).

The preceding case is a typical example of an hemolytic transfusion reaction resulting from the repeated transfusion of Rh+ blood into an Rh— subject. The process is similar to any other antigen antibody reaction. The mode of action of this phenomenon is as follows: The transfused Rh+ erythrocytes are antigenically active and stimulate the production of anti-Rh antibodies in the blood of Rh— recipients. There is no reaction to the first transfusion because as yet there are no antibodies present. However, Wiener and Peters call attention to a significant finding in their cases, namely, that there is no appreciable elevation in the patient's hemoglobin after such a transfusion. Usually the patient will not experience a reaction from the first transfusion, but only after the second or subsequent transfusions, or until there has been sufficient interval lapse to permit the development of anti-Rh antibodies in his blood against the transfused Rh+ cells, or until there is an excess of non-absorbed agglutinins.

Such reactions do not occur more often because multiple transfusions are not employed as frequently now as in the past, most institutions crossmatch the bloods, and finally, most individuals (85%) are Rh+ and therefore are not capable of being immunized by Rh+ blood. Also, Davidsohn and Toharsky[6] have demonstrated a quantitative difference in the antigen (Rh+ cells) and the anti-Rh antibodies.

It is not the purpose of this review to give a detailed description of erythroblastosis fetalis. The reader is referred to the excellent articles of Darrow[10] and Jaevert.[11] Levine and Stetson[5] advanced the theory in 1939 that the blood of pregnant women contained atypical agglutinins as a result of immunization by the products of conception. The role of the Rh factor in the production of these atypical iso-antibodies has been described by Levine and Polayes, and by Levine, Katzin, and Burnham.[3] Since 15% of all women are Rh—, and therefore capable of producing anti-Rh antibodies when stimulated by an Rh+ fetus, then approximately 15% of pregnant women should therefore reflect evidences of these circulating maternal antibodies, since the chances of the fetus being Rh+ are great, due to the fact that the Rh factor is inherited as a Mendelian dominant.[6] This is explained more simply by Burnham:[7] "The etiology of erythroblastosis fetalis resides in an immunologic incompatability between the fetus and the mother. In other words, there is present in the fetal red blood cells an antigen inherited from the father which is lacking in the mother. This antigen diffuses from the child into the mother's circulation, stimulating the formation of destructive antibodies. These antibodies, like other maternal antibodies (for example, diphtheria antitoxin) also diffuse readily into the fetal circulation, where they can attack the red blood cells which contain the antigen, thereby causing erythroblastosis." It might be added here that only those fetuses which survive 9 months of exposure to this antibody in utero and are born alive are likely to show erythroblastosis fetalis in some of its forms, as hydrops neonatorum (100% mortality), icterus gravis, or congenital anemia. Many of the infants probably do not survive the effects of these intra-uterine antibodies, and are born dead prematurely. Future investigations of stillbirths will probably show that many are Rh+ and their mothers Rh—.

The mortality from erythroblastosis fetalis is 50%[9] (Hillman and Hertig), and according to Jaevert,[8] it is 2½ times greater than syphilis, and is responsible for more fetal deaths than asphyxia neonatorum, hemorrhagic disease of the newborn, and toxemia of pregnancy.

Tranfusions have been found of value in reducing the mortality from erythroblastosis neonatorum. Katzin recommends the use of an Rh— donor, since it is known that the hemolytic process in the fetus continues for some time after birth. It has not been definitely established why this process should

continue after birth, since the author and others have not been able to demonstrate agglutinins in the fetal blood serum. It has been assumed that the agglutinins have been absorbed by the fetal tissues. The father of such an infant, or random donors should not be accepted, since the chances of their blood being Rh+ are rather high, and such erythrocytes would be rapidly destroyed by the fetus.

Katzin has recommended the following technique in determining whether erythrocytes are Rh+ or Rh—:

Technique: Use carefully cleaned small test tubes (about 8 x 0.4 cm.)

1. Place 2 drops of anti-Rh serum** in tube.
2. Add 2 drops of fresh saline suspension (2%) of red cells to be tested (this corresponds in color to that obtained by the addition of one drop of blood to 4 cc. of saline).
3. Shake and place in water bath at 37°C. for 30 minutes.
4. Centrifugate for 1 minute at 400 R. P. M., and observe sedimented blood, then resuspend gently.
5. Inspect grossly for clumping. Those clumped are Rh positive.
6. Inspect microscopically (low power) all those grossly negative. Only those negative microscopically are considered Rh negative. (A small drop for microscopic inspection may be easily removed from the test tube to a microscopic slide by means of a small glass rod.)
7. In all questionable instances, check on original saline suspension of unknown cells; be sure these are even, unagglutinated suspensions of red cells.

In March, 1941, Levine, Katzin, and Burnham reported their observations on 5 mothers whose obstetric histories consisted of toxemia, macerated fetuses, repeated abortions, miscarriages, or stillbirths. Of this group, cases 2, 3, and 5 were given blood transfusions; all had transfusion reactions, and in case 5 the reaction was fatal. Atypical (anti-Rh) agglutinins were obtained in all cases.

If it is found necessary to transfuse the mother of an erythroblastosis fetus, the preceding technique for selecting donors should be carried out, in addition to the usual method of typing and crossmatching, since only Rh—donors should be used. If donors are not so selected there is a strong possibility that the mother may have a severe or fatal transfusion reaction. Since any Rh— individual may be immunized to form anti-Rh antibodies[2] by repeated transfusions of Rh+ blood, care should be taken in the selection of all donors for these patients. If one suspects that it will be necessary to give an individual more than one transfusion, one should determine whether the patient is Rh+ or Rh—. If tests show the patient to be RH+, then the usual methods of crossmatching will be sufficient in selecting donors. However, if the patient is Rh—, only Rh— donors should be used. Because the patient does not experience a reaction after the first transfusion is no indication that subsequent transfusions can be given safely, since severe or fatal reactions are most apt to occur following the second or subsequent transfusions.

Summary

Certain transfusion reactions can be prevented if the following precautions are taken:

1. Determine the Rh factor of the red cells of all patients who are to be given multiple transfusions, all obstetrical patients, and newborn infants exhibiting signs of any of the various types of erythroblastosis.
2. If an Rh— patient is to receive multiple blood transfusions, use only Rh— blood which is otherwise compatible.
3. Obstetric patients, if Rh—, should be given only Rh— blood which is otherwise compatible.
4. Newborn infants exhibiting any of the signs of the various tyes of erythroblastosis

Continued on page 80

** We have used anti-Rh sera obtained from mothers of babies who have had erythroblastosis, such sera has been neutralized by the A and B factors of Witebsky supplied through the courtesy of Eli Lilly Co., Indianapolis.

Commercial serum may be obtained from the Blood Transfusion Association, 39 East 78th St., New York City, or from Certified Blood Donor Service, 146-16 Hillside Avenue, Jamaica, N. Y.

*The Doctor of Medicine and His Responsibility**

Alfred W. Adson, M. D., Rochester, Minnesota

Members of the North Central Medical Conference, representing the states of North Dakota, South Dakota, Minnesota, Wisconsin, Nebraska, and Iowa, have entrusted me with the responsibility of addressing this National Conference on Medical Service concerning medical problems that are of both local and national interest.

It is the duty of every doctor of medicine to prevent illness, to supply adequate medical care to those who are ill, to perpetuate the science of medicine and to encourage medical investigation. It is true that the average physician would prefer to go unregimented among his sick and administer to their needs, irrespective of race, color, creed, or financial status, rather than busy himself with administrative and political problems. However, since the courts have ruled that group health is a business and have found that medical societies are guilty of restraining trade when attempting to maintain the standards of the practice of medicine, a challenge has been issued to the medical profession: Is there a necessity for lay groups and the Federal Government to take over the control of the practice of medicine.

Has the science of medicine reached its zenith? Have the men and women of medicine become so decadent that they are unable to assume their responsibilities? Are the doctors of medicine no longer able to conduct their practice without government control? Do they lack ability to appreciate their problems? Or are they incapable of constructive leadership in the solution of the numerous responsibilities that are confronting the medical profession today? The reply is, "No".

The science of medicine has been nurtured by men and women who have advanced the knowledge of relieving pain, correcting deformities, lowering infant mortality, prolonging life and preventing illness by sanitary and public health measures. This progress must continue if civilization is to survive.

The medical profession is conscious of social and economic changes and stands ready to coöperate with, and offer leadership to, state and federal agencies in the solution of medical problems. It further believes that better medical service can be rendered by offering advice and leadership to welfare agencies than by serving as a tool under political bureaus.

The medical profession recognizes the necessity of state and federal control of communicable diseases and medical services to inmates of state and federal institutions. It appreciates its responsibility to the Armed Forces and expects to supply the needed personnel. It is willing to coöperate with welfare agencies in providing adequate medical care for the low income and indigent groups of the population; but in providing this care, it believes that the medical service is augmented when the patient-physician relationship can be maintained by permitting the patient, whenever possible, to choose his own physician. In order to protect the public from worthless, so-called medical procedures and unnecessary operations by unscrupulous individuals, it likewise believes that high standards of medical education and practice must be maintained. This applies not only to the practice of medicine in the office; it applies to the practice of medicine in the humble home or in the most modern hospital.

Although medical education begins in the medical school, it is never completed as long as the physician continues his practice. Medical schools have adopted standards of education and have required certain courses of study in order that the public might avail itself of the best practices of medicine. Medical licensing boards have further protected the public by requiring of their candidates for licensure prescribed courses of study. State laws governing the practice of medicine and conduct of physicians further protect the

* Read at the meeting of the National Conference on Medical Service, February 14, 1943.

public from irregular practices and charlatans.

Medical societies, county, state, and national, have been organized to further the education of the physician by acquainting him with the advances and new discoveries in the science of medicine. They likewise serve as administrative units in the consideration and solution of medical problems. It is obvious that the responsibilities of the respective state organizations are greater than those of the county organizations, and that the national organization is charged with greater responsibilities than those of the state organizations. However, it is also obvious that the activities of all groups must be integrated if medical problems are to be solved effectively. In some states, such as Minnesota, the administrative and the legislative bodies have the confidence of the medical profession. Likewise the medical profession has the confidence of the state administrative and legislative bodies. This confidence has made it possible for representatives of both groups to attack and solve the medical problems which are of mutual interest.

The national organization, through its respective bodies and committees, has conducted an excellent program in furthering medical education. It has crystallized the standards of medical education for the medical student as well as for the practitioner of medicine; it has investigated the claims of new and non-official remedies, foods and therapeutic measures and has further protected the public by approval or disapproval of the articles investigated. It has taken active steps through its Procurement and Assignment Committee in providing medical men for the Armed Forces without robbing communities of adequate medical personnel and has made provisions for relocation of physicians where more medical service is needed. It has acquainted the public with the important role that the science of medicine plays in their daily lives, but apparently it has not gained the confidence of the national administrative and legislative bodies that some of the state medical societies have attained. The National Physicians' Committee has made some progress in acquainting the public with the necessity of medical science, but it too had not obtained the confidence of the national administrative and legislative branches of our Government. Therefore, the recent court decision has emphasized the weakness of conducting a program of education to acquaint the public, the administrative and legislative bodies of certain states, and the national institutions with the important function of the science of medicine in our civilization. It is our duty as physicians and citizens, to assure those in administrative positions and legislative bodies that we are familiar with the social and economic changes that have thrown greater responsibilities on the medical profession and that we stand ready to coöperate with these agencies in offering leadership in the solution of the numerous problems which non-medical personnel are trying to solve.

The chief medical problem that concerns doctors of medicine and welfare agencies is that of providing adequate medical care to those who are financially unable to procure this care. This group includes those who are indigent and those with low incomes. Medical care, in its true sense, embraces more than emergency treatment for a particular illness, since it should include a rehabilitation program, such as the correction of deformities and ailments that impair the efficiency of individuals. The rehabilitation program also should include adequate and proper diets, physical training, recreation, protective clothing and housing. In most of the cities the indigent are provided with proper medical care through the charity hospitals, where competent physicians give of their services. This same group in the rural districts is not always so fortunate, since local welfare boards are reluctant to provide this care. It is in these situations that the physicians have been overburdened in assuming all of the responsibilities in providing the necessary medical care. Prior to the more recent economic changes, physicians were willing to assume this obligation because those who could afford to pay for professional services attempted to meet their obligations. However, as a result of the recent social and economic changes, the Government has taken over more and more control of the civilian's activities, and those with moderate and low incomes have been less

willing to assume their obligations of medical care and are insisting that it is the Government's duty to provide medical care and that it is the individual's privilege to squander his extra change.

The problems of this group cannot be solved by physicians alone or by federal, state, and local welfare agencies alone. Ours is a joint responsibility. Conscientious leadership by physicians working in coöperation with county, state and federal agencies can and will bring forth a solution of the problem. Medical service must be rendered, and the physician is willing to give a good portion of his services. But the Government must provide reasonable funds for the care of its indigent, as it must provide for catastrophic illness in the low income group. Nevertheless, those who come within the low income group should likewise be made to realize that they too owe a responsibility to their local, state and federal governments and should be encouraged and advised in budgeting their income and expense.

Industrial compensation has accomplished much in providing proper medical care and the necessities of life, during illness, for those employed in industrial institutions. However, there still remain a large group of individuals who receive moderate or low incomes and are desirous of securing the assurance of adequate medical service in the event of illness. Insurance companies have offered this protection through policies covering accident and illness disabilities, but again this protection only partially solves the problem, since many an insuree expects more for his premium than the insurer is able to give. In several states medical societies have attempted to develop medical service plans whereby the insuree may purchase from the doctors within the group full medical protection or medical protection for unexpected, serious illnesses. In some states under the farm security program, experimental medical service plans are being tested out by use in an attempt to find the solution of the problem of supplying medical care to the farmers and their families who are being rehabilitated. In some instances physicians are hired to render medical service to indigent and coöperative groups. Even though physicians, welfare agencies and low income groups are struggling with the problems of medical service plans, as yet a satisfactory plan for all classes has not been developed. The recipients expect more than the vendors can supply for the premiums paid.

These controversies give rise to discussions on the necessity of compulsory medical insurance. Should such a program evolve, results would be disappointing from the patient's as well as the physician's points of view if placed under the control of political bureaus, and the patient would be deprived of his free choice of physician.

Therefore, we as physicians believe that a more equitable solution of the perplexing medical problems referred to will be reached if we are permitted to consult and advise administrative officials, legislative bodies, and welfare agencies, since we are more familiar with the medical needs of our respective communities than are those who have a casual knowledge of the medical necessities.

It is befitting to quote the statement found in the opinion written by Justice Miller, of the United States Court of Appeals, of the District of Columbia, in the case of the United States of America versus the American Medical Association, and the case of the United States of America versus the Medical Society of the District of Columbia. The italics are mine.

> "It may be regrettable that Congress chose to take over in the Sherman Act the common law concept of trade, at least to the extent of including therein the practice of medicine. Developments which have taken place during recent decades in the building up of standards of professional education and licensure, together with self-imposed standards of discipline and professional ethics, have, in the belief of many persons, resulted in substantial differences between professional practices and the generally accepted methods of trade and business. As we pointed out in our earlier decision, the American Medical Association and other local medical associations have undoubtedly made a profound contribution to this development. *However, our task is not to legislate or declare policy*

in such matters, but rather, to interpret and apply standards and policies which have been declared by the legislature. That Congress did use the common law test there is no doubt. That Congress was not otherwise advised was perhaps because of the failure of the professional groups to insist upon the distinction and to secure its legislative recognition."

Does the medical profession of this country need a stronger invitation, or a more direct challenge to take an intelligent, helpful and fair stand in the enactment of legislation that not only concerns the public welfare but the welfare of medicine itself? Does not the medical profession of this country, as citizens and tax payers, have a right to express its opinion in these matters before legislation is enacted and rules and regulations adopted by some bureau? I do not share the opinion that the time for the medical profession to speak up is after such things have taken place. Neither do I have the opinion that Congress would be resentful of intelligent, courageous and fair advice on such matters. What better proof can be asked than the quotation from Justice Miller's opinion that the Court is not responsible for the absence of advice from the medical profession when Congress is drafting a law.

It is not the purpose of this paper to criticize the efforts of our national medical organization nor to criticize the efforts of the National Physicians' Committee, but it is the desire of the members of the North Central Medical Conference to express a wish that a more active program be conducted to acquaint the public, government officials, and legislative bodies with the necessity of medical science and the important role it plays in our civilization. It is essential that we as physicians dispel the fear that government administrative agencies and legislative bodies have of our medical organizations and that they be assured of our coöperation in solving the social and economic problems that confront us as a nation.

The functions of acquainting the public on matters of medical interest, assisting bureaus in formulating plans on medical care and offering constructive advice on proposed medical legislation rightfully belong to the national organization known as the American Medical Association. They could be assigned to the National Physicians' Committee, or they might even be undertaken by unifying the activities of the various state committees on public policy and legislation. Representative committees could be appointed for each of the component societies, county, state, and national. These could all be so integrated that national opinion and advice could be obtained and made available for committee hearings on legislation within a few hours' time. Through the national, state, and county committees the entire profession could be informed of proposed medical legislation. Thus, the local constituents of the respective state and federal legislators could express their views before legislation is enacted. Some states already have medical advisory committees from each county. They also have state medical committees on public policy with a physician as part-time executive chairman assisted by legal counsel. A national committee constructed on the same plan as these state committees would have to be created. A physician who has practised medicine should be chosen as the executive chairman. Both he and his legal counsel would need to be stationed in our national capital. The expense of the national committee on public policy could be financed by one of three agencies, the American Medical Association, the National Physicians' Committee, or the respective state organizations bearing the expense jointly. It would appear more equitable if each physician would be assessed each year for the specific purpose of maintaining a national committee on public policy and legislation.

Our problems are not unlike those of dentists and hospital associations. Therefore, unified effort of medical, dental and hospital associations should further the welfare of the patient.

Automobile accidents on the streets create a great stir, but tuberculosis causes three times as many deaths.—R. T. Westman, M. D., Health Off., Kansas City, Kan.

Editorials

Army's 1943 Recruiting Program Will Require 6,900 Physicians

Outline of Procedure Reveals None Will Be Commissioned Until Found Available by Procurement and Assignment Service

The 1943 recruiting program of the Surgeon General of the Army calls for the commissioning of 6,900 physicians and approximately 3,000 hospital interns and residents, it is reported in *The Journal of the American Medical Association* for March 13 in an outline of the new procedure of processing physicians, dentists and veterinarians for the Army. The program also calls for the commissioning of 4,800 dentists and 900 veterinarians.

Physicians will be procured from the following twenty states and the District of Columbia: California, Colorado, Connecticut, Illinois, Iowa, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont and Wisconsin.

The following states have already contributed more physicians to the armed forces than the sum of their 1942 and 1943 quotas and will not be called on to furnish any more physicians, except interns and residents and except special cases for specific position vacancies, during 1943: Alabama, Arizona, Delaware, Georgia, Idaho, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, South Carolina, Tennessee, Texas, West Virginia and Wyoming.

It is stated that at present there will be no procurement of physicians, except interns and residents and in special cases for specific position vacancies, in those states not listed above. There will be no procurement of dentists, except special cases for specific position vacancies, in the following sixteen states: Alabama, Arizona, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas and Virginia.

At the present time there are no restrictions on the recruiting of veterinarians.

In the instructions issued by the Army it is pointed out that the Surgeon General has discontinued all medical officer recruiting boards and that under the new procurement program no physician, dentist or veterinarian will be commissioned in the armed forces of the United States until he has been declared "available" by the Procurement and Assignment Service of the War Manpower Commission.

In each state the Procurement and Assignment Service has set up three state chairmen: medical, dental and veterinary. Each of these prepares a monthly quota list of physicians, dentists and veterinarians who are apparently suitable and who are available, for commissioning in the Army of the United States. This list is submitted to the central office of the Procurement and Assignment Service which sends a communication inviting such individuals to apply for service with the armed forces. On the reply card enclosed with the invitation the individual states his preference for the Army, Navy or Medical Department of the Air Forces. These reply cards are sent by the potential applicants to the state chairmen of the Procurement and Assignment Service who in turn submit lists of such potential applicants to the Officer Procurement Service of the Army.

On receipt of such lists the officer procurement district office contacts the potential applicant and arranges for an interview regarding a commission.

Applicants will be requested by the officer procurement district office to complete all papers and take all steps required of them within fourteen days of the date of such request. If this is not complied with, a report thereon will be transmitted by the officer procurement district office to the state chairman of the Procurement and Assignment Service.

The decision as to the grade and appointment to be recommended for each candidate rests with the Surgeon General, not with the Officer Procurement Service.

Invalid Diets and Food Rationing

Of interest to all who are concerned with diets for invalids is Ration Order 13, issued by the Office of Price Administration under date of February 9, 1943. This order covers all canned, dried, and frozen fruits and vegetables. Article 11, Section 2.5 of the order reads as follows:

"Consumers who need more processed foods because of illness may apply for more points.

(a) Any consumer whose health requires that he have more processed foods than he can get with War Ration Book Two, may apply for additional points. The application must be made, on OPA Form R-315, by the consumer himself or by someone acting for him, and may be made in person or by mail. The application can be made only to the board for the place where the consumer lives. He must submit with his application a written statement of a licensed or registered physician or surgeon, showing why he must have more processed foods, the amounts and types he needs during the next two months, and why he cannot use unrationed foods instead.

(b) If the board finds that his health depends upon his getting more processed foods, and that he cannot use or cannot get unrationed foods, it shall issue to him one or more certificates for the number of points necessary to get the additional processed foods he needs during the next two months."

The application form referred to above, OPA Form R-315, is apt to be somewhat confusing to patients. It is titled "Sugar Special Purpose Application" and was developed primarily to meet the need for home canning. It is being used temporarily, until a more adequate form can be gotten out.

It is anticipated that the procedure indicated in Section 2.5 above may be changed somewhat in the future, in which case due notice will be provided.

The National Conference on Planning for War and Post War Medical Services

Report of Thomas A. Foster, M. D., Portland, Maine, Delegate to the American Medical Association

On March 15th your delegate to the American Medical Association attended the sessions of the National Conference on Planning for War and Post War Medical Services, held at the Waldorf Astoria, New York. The Program follows:—

The morning session convened at 10.00 A. M., with James E. Paullin, M. D., President, American College of Physicians, President-Elect, American Medical Association, presiding.

War and the Migration of Tropical Diseases, Thomas T. Mackie, M. D., Lt. Col., Medical Corps and Executive Officer, Tropical and Military Medicine, Army Medical School, Washington, D. C.

Epidemiology of Influenza, Thomas Francis, Jr., M. D., Prof., Dept. of Epidemiology, University of Michigan School of Public Health, Ann Arbor, Mich.

Malaria—A World Menace, Lowell T. Coggeshall, M. D., University of Michigan School of Public Health, Ann Arbor, Mich.

Nutritional Diseases as a Post War Problem, John B. Youmans, M. D., Assoc. Prof. Med., Vanderbilt University School of Medicine, Vanderbilt University Hospital, Nashville, Tenn.

Brigadier General, Fred Rankin, M. C., U. S. A., President, American Medical Association, presided at the afternoon session.

Postwar Needs for Medical and Other Trained Personnel, Edward C. Elliott, Phd., LL. D., Pres., Purdue University, Manpower Commission, Washington, D. C.

Postwar Channeling of Drugs and Medical Supplies, C. F. Shook, M. D., Col., Medical Corps, U. S. Army, Washington, D. C.

Trends in Scientific Research, A. R. Dochez, Rockefeller Institute for Medical Research.

The titles of the papers will indicate the nature and tone of the discussions. Your delegate wishes to report that the speakers regarded present and future conditions as serious indeed, and bespoke the thoughtful consideration of the medical profession in the issues presented.

Lt. Col. Mackie indicated that many tropical diseases could and probably would be transported to Hawaii and the United States. Airplane travel makes it possible for an in-

Continued on page 75

Maternal and Child Welfare

Abortion

Abortion is the cause of 25% of all maternal deaths in this country, the cause of 50% of all deaths attributed to puerperal sepsis. Dunn (Chief Statistician of the Bureau of Vital Statistics, Washington) states that between three and four thousand women die annually in the United States following abortion. Taussig estimates that 700,000 women each year undergo some type of abortion. A pool of available statistics indicates that 20%-30% of all pregnancies in cities and 5%-15% in rural districts are terminated prior to the period of viability. Of these abortions 33%-66% are induced. (The latter figure was derived from a questionnaire sent to Maine physicians and cited in the *Encyclopedia of Social Sciences.*) Since spontaneous abortions are seldom fatal and therapeutic abortions very rarely so, the vast majority of abortions that give rise to mortality statistics are illegally induced.

The above figures demonstrate the seriousness of the abortion problem in this country. If illegal abortion could be done away with our maternal mortality would immediately be reduced by one-quarter. At least one thousand women who will be dead at the end of 1943 would then be alive. These women are not predominately "unfortunate girls" who take this way to avoid the shame of illegitimate birth, they are not "immoral women" who wish to rid themselves of the incumbrance incidental to their sinful mode of life. To the contrary 80%-90% of them are "respectable married women" who have already borne children and who are impelled largely by economic motives to take this means of limiting their families.

The average ethical physician views the question of abortion with mingled fear and indifference. His fear is a wholesome horror of becoming in any way, however innocently, associated with an abortion case. Should his name be so associated his professional reputation might well be jeopardized. His indifference is an outgrowth of the same fear. He knows nothing about abortion because he does not wish to know anything. In medical school we were warned to be always on our guard to avoid the suspicion of evil, we were told of the tricks that women sometimes employ to trap the unwary young physician into performing an abortion unwittingly. We were taught very little else on the subject. Our first impulse when a woman broaches the question of the interruption of pregnancy is to get her out of the office as fast as possible. We don't care where she goes as long as she gets out. This fact is so well known that few women would think of asking their family physicians about abortion. The woman who is unwillingly pregnant discusses the fact with her bosom friends and can usually find one who is only too pleased to direct her to some quack who proceeds to mutilate her and, now and then, to kill her.

We would be the last to encourage the family physician to be more lenient on the subject of abortion. Our plea is for him to be less so. Not only to recoil in horror from performing an illegal abortion himself, but to take more active steps to prevent his patients from falling into the hands of those who do. The woman who hysterically declares that she will not have a child (or another child) and that she is ready to take desperate measures to get rid of it is in dire need of guidance. If she is coldly shown the door she will probably rush out and do herself an injury or, more likely, pay someone else to do it. If she receives sympathy for her misfortune but is sadly told that the doctor can do nothing about it the result will be the same. If he tells her she will be doing wrong, that she will be liable to arrest, and that she may die she will answer that she considers it wrong to bring a child into the world that she cannot properly care for (meaning anything from feeding it to giving it a college education, according to her standard of living) and she will add dramatically that she would rather die than have this baby. She will half believe her own statements and again the result will be the same.

It takes time and a firm conviction to persuade a woman who has made up her mind to

be rid of an unwanted pregnancy not to have an abortion. Not all women can be so persuaded no matter how forcefully the facts are put before them, but facts alone will influence a woman so situated. And it is the physician's duty to present the facts whenever the need to do so arises.

The possibility of death should be mentioned. The statistics cited at the beginning of this article prove that the possibility is by no means remote. But this should not be the main argument. The woman could probably cite a dozen cases among her acquaintance where abortion has decidedly not been followed by death. Her friends are alive and apparently happy today. The threat of legal consequences is still more futile. The law is clear enough, but who ever heard of a woman being brought into court on the charge of abortion? Even the abortionist is almost never indicted except on rare occasions when his victim is dead.

Mortality is not by any means the most immediate hazard of abortion. There are however serious, though less obvious ill effects of which one or more follow nearly every illegal operation.

Brill, the well-known psychiatrist, states that many psychoses are precipitated by abortion. Of 537 patients interviewed by one of us from one to three months after an abortion one-third stated that they felt "blue", depressed or overcome by a sense of guilt because of the step they had taken. The cancerophobia of middle life can often be traced to an early abortion, particularly if it has been followed by sterility. Marriage counsellors find that marital disharmony is a frequent consequence, each of the partner blaming the other for the step which at the time both were agreed upon. But mental sequellae are vague, intangible, and difficult to correlate. There are other more definite after-effects which may give the prospective foeticide pause if they are brought to her attention.

There are few women who can face a long serious illness or years of semi-invalidism without a qualm, yet the former is not rare and the latter is very frequent following abortion. Often the more remote ailments are not attributed by the patient or her physician to their true cause. For every woman who dies following abortion there are four or five who become seriously ill. Peritonitis, septicemia, salpingitis, salpingo-oöphoritis, pelvic abscess, hemorrhage and secondary anemia are foremost among the immediate complications of induced abortion.

In Russia at the beginning of the present regime abortion was legalized and any woman who preferred it to childbearing was entitled to have the operation performed at a public hospital. After a few years the privilege was revoked because experience showed that the effects of abortion were weakening the womanpower of the country. It was a mass experiment which demonstrated that the operation is crippling even when performed under aseptic conditions by skilled surgeons. What then must be expected when, as in this country, the operator is a disreputable lawbreaker working under conditions of secrecy and haste, whose only wish is to get his bloody work done and collect his money without being caught? This is true of the abortionist in the big cities where the Abortion Racket flourishes and where you sometimes hear reputable men who should know better speak of a "good" abortionist. The term is paradoxical. The practised abortionist who has a fancy suite of offices to impress the ladies who can afford to pay his exorbitant prices works with the same motives and under the same anxieties as his humble colleague, the village quack. He may and usually does keep several thousand dollars in cash handy to blind the eyes of justice, but he also has a back door always open for a hasty exit.

Taussig, who visited Russia when the results of the experiment were becoming manifest, reports that immediate complications occurred in 10% of all cases, remote complications in 27%. Among the chronic conditions which developed in those who had had abortions were endocervicitis, endometritis, and endocrine disturbances. Forty-three percent of the women complained of menstrual disorders which had not been present prior to abortion. Hydatidiform mole and chorioepithelioma were seen more frequently after abortion than following normal childbirth.

Girls and young married women, while de-

termined to be rid of an untimely pregnancy, usually look forward to having a family later when it may be more convenient. These recoil at the thought of permanent sterility. At a sterility clinic in New York 22% of 483 patients interviewed confessed to having had one or more illegal abortions in the past. In Russia 35% of those who wanted babies but were unable to conceive had been aborted earlier. These are among the most pitiful of the childless because they realize that they themselves are responsible for their fate.

Among those who do carry out their plans "at a more convenient time" parturition is likely to be complicated. Placenta previa is four times more frequent in those who have had abortions than in those who have not. Premature separation of the placenta, uterine inertia, rigid cervix, adherent placenta and postpartum hemorrhage all occur more frequently in these patients.

Facts such as these should be soberly presented to the girl or woman who declares that she will "get rid of it" in spite of every argument. Many can be dissuaded and will live to love the child and thank the doctor who took the trouble to convince them that an abortion is more dangerous than having a tooth pulled, a fact of which not a few seem to be ignorant.

If the physician can go further—help the single girl to make peace with her family, arrange for her confinement in a place where gossip can be reduced to a minimum, help the married woman to adjust herself to an attitude of acceptance, and show both that a baby is not the worst calamity that can come out of a pregnancy he will have done a fine piece of preventive medicine.

Your Committee on Maternal and Child Welfare.

The Early Diagnosis Campaign for the Prevention of Tuberculosis

The National Tuberculosis Association as early as 1928 found that very few persons took sanatorium treatment in the first stage, when the disease was a minimal one. The Early Diagnosis Campaign was the first project recommended by its advisory committee. A nationwide educational campaign through the month of April, with suitable posters, pamphlets, films, window displays, exhibits, radio talks, newspaper editorials and special speakers, are the avenues of publicity to inform the public regarding tuberculosis and its early diagnosis. From the beginning of the Early Diagnosis Campaign, in 1929, the position of the physicians in the control of tuberculosis is emphasized. Every year a State Chairman is appointed by each state and a slogan is made by the National Association. The 1943 slogan chosen is "Follow the Example of the Armed Forces, a Chest X-ray." This method has uncovered one in a hundred of the men examined had tuberculosis and were rejected. The cost of Tuberculosis in World War I has now amounted to over $1,000,000,000. In the present war the armed forces have made preparation to keep Tuberculosis out of the service. This practice will reduce Tuberculosis in the Army, but it adds to the civilian problems of Tuberculosis Prevention as follows:

1. Rejected men must be treated and in some instances retrained.
2. Health problems caused by population shifts, housing, sanitation, and nutrition must be solved.
3. The emotional strain people undergo through necessary home adjustments to assist in meeting the manpower need is a factor.
4. Depletion of doctors and nurses and insufficient number of hospital beds are some problems we must be alert to if we are even to hold the gains we have made in Tuberculosis Prevention.

This adds to the burden of tuberculosis and public health workers in the State. We must not allow 250 people in Maine each year to die of Tuberculosis. If we follow the example of the army and X-ray large groups of workers, we shall uncover the disease so that they may be treated. There is no good reason why a large industrial plant should permit diseased men and women to work with other persons who are not infected, any more than in the armed forces. The Chairman selected by the Maine Public Health Association this

year is Mrs. Harvey D. Granville, Kezar Falls, who has been a tireless worker in the field of Tuberculosis Prevention. As Chairman of the York County Tuberculosis Association since it was organized soon after the first World War, Mrs. Granville has had no small part in reducing the death rate in Maine from 49.1 per 100,000 in 1931, to 29.2 in 1941, a decrease of 19 points per 100,000. This figure is quite a little below the National rate of 44.4 in 1941. The death rate for 1942 has not been released by the U. S. Public Health Service. This marked reduction has been achieved first by the great interest of the physicians through the State; second, by the National and State Tuberculosis Associations and their nursing service, with its affiliated county associations through the State; third, by the widespread work of the State Bureau of Health and its nursing service and the sanatoria and their clinic service; fourth, by the added interest of the general public through the Christmas Seal Sale and the Early Diagnosis Campaigns.

National Conference—Report of Delegate—Continued from page 71

fected patient to travel during period of incubation from the tropical countries to the U. S. A.

Influenza which fortunately has been quiescent throughout the world may appear suddenly in one or many sectors. And at the present time the medical profession has no knowledge of any sure and effective preventative or cure.

Malaria, in contrast to influenza, has appeared in many, many places. Eighty-five percent of our troops in Bataan suffered from the disease. Fifty percent of some garrisons in South Africa have been afflicted at times. It is constantly on the increase over the world. The supply of quinine and atabrine is limited. The danger of a great spread of this disease is real.

Nutritional diseases due to a minimal supply of vitamins face the population. A careful use of our food and supplementary food stuffs was outlined by Dr. Youmans. A scientific study on a long time view basis is under way.

In the afternoon, Dr. Elliott, President of Purdue University presented the needs of our armed forces for trained medical men and the serious drain from our civilian population which this produced. He made no prediction but pointed out that certain factors, namely the length of the war, the number of doctors wounded, killed or taken prisoners, the number of young men graduated each year, would affect the whole profession. He suggested that the medical schools might be enlarged and post-graduate institutions expanded. Perhaps one-half the total number of civilian practitioners would be called.

A plan for handling surplus drugs and supplies was discussed by Col. Shook, who said that the mistakes following the last war must not happen again.

Dr. Dochez gave an interesting account of the present trend in Scientific Research. The National Academy of Science, a large and representative association of scientific men, had coöperated with the government through the National Research Council. The Division of Medical Sciences of the National Research Council are working on many problems, particularly problems affecting adaptation of the human body to stresses and strains of modern fighting in the air.

All the speakers spoke from a wide knowledge of subject and succeeded in holding their audience interested up to the last minute.

In the evening the delegates were invited to attend a banquet at the Waldorf Astoria under the auspices of the Finlay Institute of the Americas. The speakers were: Mr. Basil O'Connor as President of the National Foundation for Infantile Paralysis and President of the Finlay Institute of the Americas; Mr. Fred Keppel of the Carnegie Foundation; Richard Allen of the Red Cross, who has just returned from a trip to North Africa and the Near East; Mr. Nelson Rockefeller, Coördinator of Inter-American Affairs, and Dr. Morris Fishbein, Editor of *The Journal of the American Medical Association.*

Dr. Fishbein spoke with his usual force and vigor and once again upheld the policy of the American Medical Association to support medical practitioners to practice in the traditional American Way allowing the patient free choice of physicians, and the Doctor freedom from bureaucratic domination.

Special Warning Bulletin

To the Members of the Maine Medical Association:

The following Special Warning Bulletin has been prepared jointly by the United States Public Health Service and the Committee on Industrial Ophthalmology of the American Medical Association, and sent to us by C. W. Peterson, M. D., Secretary of the Council on Industrial Health, of the AMA, for distribution to all physicians.

Doctor Peterson states in his letter, accompanying the Bulletin, that "It is recognized that relatively few cases of epidemic kerato-conjunctivitis may be reported in some areas which are not so essentially industrial as others, but the condition has appeared so extensively throughout the country that the Committee on Industrial Ophthalmology hopes physicians everywhere may be prepared to meet the situation."

Frederick R. Carter, M. D., *Secretary-Treasurer.*

SUBJECT: Epidemic Kerato-conjunctivitis.

Incubation period: five to ten days.

Clinical Manifestations. The onset may be preceded by a low fever and mild generalized malaise. The local ocular symptoms are merely those of a foreign body or conjunctival irritation. One eye is usually affected first, and in a large percentage of cases the second eye becomes infected within five to eight days. Preauricular and submaxillary glandular involvement with tenderness is common in a high percentage of cases.

Edema of the lids and the conjunctiva, especially the transitional fold, is very frequent. The conjunctiva presents the appearance of a simple purulent conjunctivitis but with little or no formation of pus. Small areas of pseudo-membrane are not infrequent and when removed leave either small white dotted points or some bleeding points. The bulbar conjunctiva becomes edematous early. At this stage, there is some lacrimation and photophobia, but real pain and blepharo-spasm do not appear until the cornea becomes involved.

The percentage of cases in which corneal involvement occurs varies from 50% to 90%. In six to twelve days after the conjunctivitis appears, the cornea becomes involved by the appearance of discrete gray infiltrates that lie in and immediately under the epithelial layer of the cornea. They may be confined to the periphery of the cornea but in a large percentage of cases involve the pupillary area of the cornea directly. These infiltrates are discrete and seldom become complicated by an erosion of the corneal epithelium with resultant staining with fluorescin. The extent of visual impairment depends upon the number of infiltratesand their location.

Clinical Course: The disease is self-limited. In the majority of instances, the conjunctivitis disappears spontaneously in 14 to 18 days. The corneal complication may disappear in seven days or may last for many months. The longer they persist the greater is the danger of permanent visual impairment.

Laboratory Findings: Scrapings of the conjunctiva show a preponderance of monocytes. Cultures and smears are either negative or show the usualcontaminations.

Treatment: There is no specific treatment that has shown a definite influence upon the course of the disease. During the acute stage the eyes should be kept clean with irrigations of boric acid, normal saline, or one to five thousand oxycyanid of mercury. If there is much photophobia, 1 per cent holocaine may be instilled at frequent intervals. Five per cent sulfathiazole ointment has been used, as has 5 per cent solution of sodium sulfathiazole sesquihydrate. For persistent corneal infiltrates, x-ray has seemingly yielded some results.

Period of Infectivity: It is not yet known how long the danger of transmission to others exists. At present for practical purposes a sufferer from Epidemic Kerato-conjunctivitis may be allowed to return to work when the active conjunctivitis has disappeared.

Preventive Measures: At present the only preventive measure known is complete isolation of infected persons. Inasmuch as the disease has been transmitted through medical personnel, the most meticulous asepsis must be insisted upon. Not only must physicians and nurses wash their hands thoroughly with soap and water after each patient, but also eye droppers, solutions, instruments, etc., must be sterilized to prevent infection of non-contaminated persons. The infected individual must be told of the danger of transmission of this disease to others, not only in the plant, but even in the home surroundings. It is suggested that in industrial plants where Epidemic Kerato-conjunctivitis has made its appearance the following methods of procedure be adopted:

1. In smaller plants with a limited personnel, every individual with a red eye should be stopped at the entrance of the plant and sent direct to the plant Physician to determine whether or not Epidemic Kerato-conjunctivitis is present.
   In larger plants where such a procedure is not possible, supervisors and foremen should be instructed in detail to make rounds immediately when a fresh shift starts, and send any individual with a red eye to the medical office.

2. If the cases are to be treated at the medical department of the plant, a separate room should be set aside for such cases and in that room there must be exercised the most scrupulous asepsis even to washing off the arms of the chairs in which the patients sit. Aside from the aseptic and separate care of the recognized cases of the disease, special cleanliness of the hands of the physician in the general clinic should be maintained, with the use of an effective disinfectant between cases, lest the infection be spread by means of undiagnosed cases, especially those suspected of having foreign bodies in the eye.

3. Every case of Epidemic Kerato-conjunctivitis should be excluded from the communal facilities of the plant until the inflammation has subsided to the point where the plant physician considers it no longer transmissible.

4. Explicit instructions should be given to every individual regarding the danger of transmission, and emphasizing the decrease in the war effort as a result of the time lost from Epidemic Kerato-conjunctivitis.

5. The local health authorities should be notified immediately of the existence of individual cases.

This statement has been prepared jointly by the United States Public Health Service and the Committee on Industrial Ophthalmology of the American Medical Association, for distribution to all physicians.

Necrologies

Fred H. Freeman, M. D.,
1878-1943

Fred H. Freeman, M. D., of Gardiner, Maine, died March 10, 1943, of a coronary thrombosis.

Doctor Freeman was born March 26, 1878, at Sterling, Connecticut, the son of George I. and Mary P. Freeman. He was a graduate of Worcester Academy, Worcester, Massachusetts, and Brown University, Providence, Rhode Island. His medical education was obtained at the University of Vermont Medical School, from which he was graduated in 1909. He interned at the Taunton (Mass.) State Hospital, and was on the staff of the Bangor State Hospital for about two years. He had practiced medicine in Surrey, Sangerville, and Pittsfield, before locating in Gardiner last September.

Doctor Freeman was a member of the American Medical Association, Maine Medical Association, and Kennebec County Medical Association. He was a member of the Protestant Episcopal Church for 35 years. He was also a member of the Philtoma Lodge, A. F. and M., of Pittsfield, and of the American Legion. During World War I he serevd overseas as a First Lieutenant in the Medical Corps, and after the Armistice worked in several London hospitals. He was held in high regard by his medical associates and the clientele he served.

Doctor Freeman was married to Jessie Wheeler of East Wallingford, Vermont, on September 28, 1912. He is survived by his wife, a foster-son, Leon Kendall, and a foster-daughter, Mrs. John W. Lane, both of Farmingdale.

George F. Miller, M. D.,
1876-1943

George F. Miller, M. D., of Belfast, Maine, died March 22, 1943.

Doctor Miller was graduated from Tufts College Medical School in 1908. He practiced medicine in Boston, Massachusetts, before locating in Belfast, twelve years ago.

He was a member of the American Medical Association, Maine Medical Association, and the Waldo County Medical Society, and was a past president of his County Society.

He is survived by his wife, Daisy C. Miller, of Belfast.

Adelbert Franklin Williams, M. D.,
1870-1943

Adelbert F. Williams, M. D., many years a practicing physician in Phippsburg, and recently of the Bath Iron Works Corporation hospital staff, died March 11, 1943, in the Bath Memorial Hospital.

Born at Gardiner, Maine, August 11, 1870, the son of Frank B. and Marilla Rairden Williams, he was graduated from Dartmouth Medical College in 1897. Doctor Williams practiced medicine in Phippsburg for twenty years, entering military service in 1917. He was a Captain in the Army Medical Corps in World War I, serving in France. After the war, he was post surgeon at Fort Williams for a time and later was with the Veterans' Administration at Boston, Portland, and Togus, and was chief medical officer at the Portland regional office for ten years.

He was a member of the American Medical Association, Maine Medical Association, and Lincoln-Sagadahoc County Medical Society.

Surviving are his widow, a son, Col. John W. Williams, U. S. A., Washington, D. C., and two daughters, Miss Marilla V. Williams of Brooklyn, N. Y., and Mrs. Thomas Totman of York Beach.

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County News and Notes

Paid-Up Membership for 1943

Piscataquis County Medical Society
Franklin County Medical Society
Aroostook County Medical Society
Hancock County Medical Society

Hancock

The annual meeting of the Hancock County Medical Society was held in November, 1942, at Ellsworth, Maine. Officers for the ensuing year were elected as follows:

President, Charles C. Morrison, Jr., M. D., Bar Harbor.

Vice President, Hyman Millstein, M. D., Southwest Harbor.

Secretary-Treasurer, Edward Thegen, M. D., Bucksport.

Delegate to the Maine Medical Association, Dr. Thegen. Alternate, R. V. N. Bliss, M. D., Bluehill.

Board of Censors, Raymond W. Clarke, M. D., Ellsworth; Philip L. Gray, M. D., South Brooksville, and Dr. Millstein.

Penobscot

The regular monthly meeting of the Penobscot County Medical Association was held at the Bangor House, Bangor, Maine, on Tuesday, February 16, 1943.

After the dinner the following Round Table Discussion on Vitamins was presented:

A. W. Fellows, M. D., Children.
W. R. Gumprecht, M. D., Chest.
W. J. Hammond, M. D., Nervous System.
E. L. Herlihy, M. D., Liver.
H. L. Robinson, M. D., Thyroid.
M. A. Vickers, M. D., Allergy.
J. E. Whitworth, M. D., Eye, Ear, Nose and Throat.

There were forty-six present.

FORREST B. AMES, M. D.,
Secretary.

Washington

The regular Fall meeting of the Washington County Medical Society was held at Dennysville, Maine, on Thursday, October 29, 1942, at 6.30 P. M.

W. H. Bunker, M. D., of Calais, gave an instructive talk on the "Wagenstein Tube Therapy." His talk was followed by a general discussion.

Officers for the ensuing year were elected as follows:

President, Walter N. Miner, M. D., Calais.

Vice President, James C. Bates, M. D., Eastport.

Secretary-Treasurer, Allen H. Knapp, M. D., Calais.

Delegate to the Maine Medical Association, Willard H. Bunker, M. D., Calais.

Alternate, DaCosta F. Bennett, M. D., Lubec.

Censor for three years, Joseph Capello, M. D., Lubec.

The regular meeting of the Washington County Medical Society was held at the St. Croix Hotel, Calais, Maine, on Thursday, March 18, 1943, at 6.30 P. M.

Following the dinner, and short business meeting, a lively and informative discussion took place on *Dermatology*. H. S. Everett, M. D., First Vice President of the New Brunswick Medical Society opened the session with a discussion of the treatment of *Scabies and Pityriasis Rosea*. Everyone took part in the symposium, each contributing his bit.

There were twelve present; ten members and two guests. The guests, L. W. Brownrigg, M. D., and H. S. Everett, M. D., both of St. Stephen, were duly voted in as members of the Society.

Allen H. Knapp, M. D.,
Secretary.

New Members

Androscoggin

Paul J. B. Fortier, M. D., 190 Bates Street, Lewiston, Maine.

*Members in Military Service**

Aroostook

Toussaint, Leonid G., Fort Kent

Lincoln-Sagadahoc

Smith, Jacob, Bath

Oxford

Courville, Albert L., Rumford

Somerset

Brann, Henry A., Madison

Sullivan, George E., Bingham

* These names of members in military service have been reported to the Journal office since publication of the preceding issue of the Journal, and supplement all lists published under this heading beginning with the September 1942 issue.

Notices

War Conference

The medical, surgical and industrial hygiene experts who are so ably safeguarding the well-being of more than 20 million industrial workers have agreed to pool their knowledge and exchange their experiences regarding the many new and complex problems of today's wartime production. For this purpose their organizations—The American Association of Industrial Physicians and Surgeons, The American Industrial Hygiene Association, and The National Conference of Governmental Hygienists—are combining their annual meetings in a four-day "War Conference" at Rochester, New York, May 24-27, 1943.

American Board of Obstetrics and Gynecology Examinations

The general oral and pathological examinations (Part II) for all candidates will be conducted at The Hotel Schenley, Pittsburgh, Pennsylvania, by the entire Board from Thursday, May 20, through Tuesday, May 25, 1943.

Candidates for *reexamination* in Part II must make written application to the Secretary's Office not later than April 15, 1943.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

The Significance of the Rh Factor of the Blood—Continued from page 65

should be given Rh— blood in order to get the greatest benefit from it.

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*Five Hundred Neuro-Psychiatric Casualties at a Naval Hospital**

By A. Warren Stearns, Commander, Medical Corps, United States Naval Reserve, and
Robert S. Schwab, Lieutenant Commander, Medical Corps, United States Naval Reserve

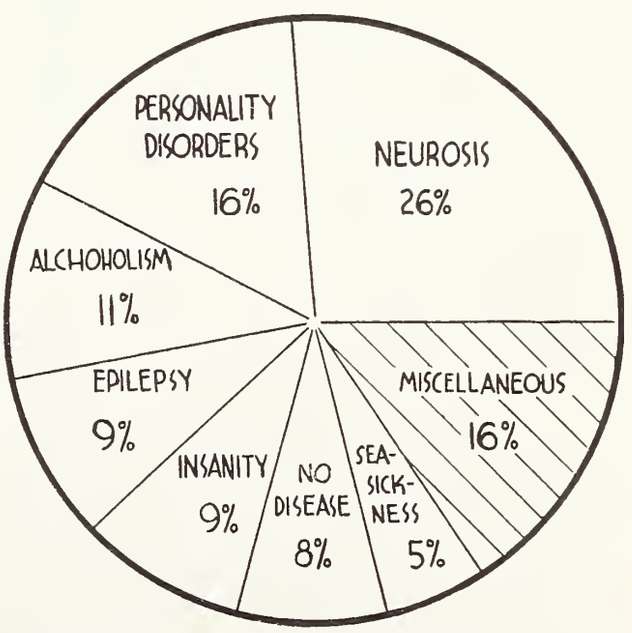
I. Introduction.

During the past year there have been 582 admissions to the Neuro-Psychiatric Clinic at the United States Naval Hospital at Chelsea. This has comprised about 7 per cent of the total admissions to the hospital.

II. Types of Inadequacy Encountered.

There has been a considerable literature from various sources having to do with the neuro-psychiatric component of military medicine. This material has to do largely with rejections and the prediction of the types of persons who would go to pieces under the stress of military service. Most of the material dealing with casualties has come from the experience of the last war, and there has been an inference that because of great strides in neuro-psychiatry, the experience of this war would be entirely different. For this reason it seems appropriate to present the record of a Neuro-Psychiatric Service in a naval hospital during the past year. This is a record of 500 consecutive cases who have been accepted for military service, who passed through the initial training period and were actually assigned to duty. It will be seen that these are cases whom the Navy has tried to use but who have failed. They were actually admissions to the N. P. wards and do not include an extensive officer personnel seen in consultation nor a large consulting service seen from other wards in the hospital and from other ships or stations nearby.

CHART NO. 1



Principle Diagnostic Groups in 500 N. P. Cases.

* Read at a meeting of the Boston Society of Psychiatry and Neurology on December 10, 1942.

Approved for publication by the Bureau of Medicine and Surgery on March 3, 1943.

It will be readily seen from our experience that a relatively few of the neuro-psychiatric problems transcend all others in importance. We might refer to them as the big five. Overshadowing all others in importance is the group called psychoneuroses. Although there are ten sub-divisions of psychoneurosis in the Navy nomenclature, we rarely used more than three. There may be in the minds of some a clear cut distinction between these various groups, but for practical purposes they can be handled as one, and rarely have we found it important to make sub-divisions. This group covers the whole gamut of emotional experience and, of course, overlaps very largely with personality disorders. It is often a moot question as to whether the diagnosis of constitutional inferiority or psychoneurosis should be used. Needless to say, a substantial number of those with the latter diagnosis might properly have been called by the former. We do not find the group as met here to present many new features. It is the same old story as seen in civil life, colored, of course, by the language and experience of the military service. We are of the opinion that the group might properly be divided into two groups. The first is the chronic nervous invalid who inadvertently or improperly gets into the military service where his inadequacy soon results in his being surveyed. He is so frail that he is not able to withstand the ordinary vicissitudes of the military service. There is another group whose history would seem to indicate at least average stability, but who have been subjected to unusual degrees of stress making them nervously exhausted or emotionally disturbed. We believe the prognosis to be better in the latter group if seen early. Our opinion is that this number represents a very small percentage of the neurotics admitted to the hospital. We believe there is a much larger group of neurotics scattered throughout the various other services. A great deal of the chronic indigestion and chronic backache appear to have an emotional background. It has not been our policy to return frank psychoneurotic persons to duty, although an occasional person, whose symptoms were mild and whose assets in other fields seems great, has been returned tentatively.

TABLE NO. 1

Principle Diagnostic Groups.

	Total
Neurosis	121
Personality Disorder	73
Alcoholism	49
Epilepsy	43
Insanity	42

We have seen a large number of both officer and enlisted personnel in consultation who had complaints suggesting functional nervous disease but who were carrying on at their work, were not disabled, and who seemed relatively good risks. These have been advised and sent on their way. From our experience it would seem unwise to hospitalize a neurotic person unless his symptoms are disabling, or unless he is considered unfit for duty, and a probable subject for survey. We have seen many neurotics who when they came to the hospital were anxious to return to duty, but with only a brief hospital stay there has been a deterioration in morale and symptoms have become aggravated rather than ameliorated. The completion of a survey with a recommendation for discharge often results in the almost complete disappearance of symptoms.

The next group in size has to deal with personality disorders. Here again, while there are seven sub-divisions in the Navy nomenclature, we have made little attempt to subdivide this group. It is a cosmopolitan group, used as a sort of a "catch-all" to include all those behavior disorders not frankly insane or feebleminded, which have elements justifying a belief in a psychopathic background. If one uses the term liberally, of course, it would include all of the personality problems incident to military service. If the term is used in a narrow sense, it would be a very much smaller group. There is apparently a good deal of uncertainty as to its use in the U. S. Navy. In the last report of the Surgeon General, of 197 cases invalided from service with this diagnosis, but 149 were said to have existed prior to enlistment.[1] Of course, this violates the concept of the group as on a constitutional basis. An attempt to clarify our attitude by a review of the literature left us still more confused.[2] It seems to us better to accept the concept as

behavioristic and let it go at that. At times a single episode stands out with sufficient clarity to justify the inference that there is an underlying emotional instability. This applies particularly to a number of young persons who have attempted suicide in an emotional upheaval, yet who show little other evidence of constitutional psychopathy. It has not seemed to us safe to send such individuals back to duty because we have believed them to be excessively vulnerable to stress as evidenced by the experience which brought them to the hospital.

By far the larger group in which this diagnosis has been used are those with a history of being problem children, doing badly in school, running the gamut of clinics, jails, psychopathic hospitals, and present to the military, as to society at large, one of its most serious problems. We have little to offer except to say as emphatically as possible that such individuals should be detected early and kept out of the service. Of course, parole officers, prison officials and the courts are glad to have the military assume responsibility for their incorrigibles and it is true that we have little data indicating to what an extent such individuals are hazards. We are informed by Mr. Fred Gilmore,** the Supervisor of Parole for the Massachusetts Training School, that a very large number of his wards are in all branches of the military service, and he estimates that more than 90 per cent of them are doing well. Obviously, this matter should have careful study.

Alcoholism presents a large and distressing group and, in our experience, a quite unnecessary problem. It would seem futile to enlist a chronic alcoholic but greater, by far, in our experience, has been the number of retired individuals who have come back into the service and have been found to be confirmed drunkards. Obviously, the most cursory scrutiny of the individual's career would indicate this, but there appears to be a high degree of tolerance in the Navy toward the drunkard. Because some persons who are competent occasionally get drunk, it is assumed that all drunkards are competent. Nothing could be farther from the truth. Many of these individuals not only betray the military but their family, and utterly disregard all their responsibilities.

The next group is the epileptic. It is surprising how many individuals have an occasional convulsion. A few of these appear to have had their first attack after entering the service, but in most cases it is merely the continuation of a trouble with which the individual has long been affected. He may not have a very clear conception of his trouble, and the enlistment is not always fraudulent. The large number of frank cases of epilepsy who enlist is sufficient evidence that merely asking a question on an application blank is not an adequate method of trying to keep epileptics out of the military service. It would almost seem as though all epileptics at one time or other enlist in either the army or navy, and many do it again and again. All suspected epileptics have been studied with the electro-encephalograph which one of us has discussed in another contribution.[3]

There have been forty-seven who have been diagnosed as psychotic with the following sub-divisions:

TABLE NO. 2

Types of Insanity

Manic Depressive	14
Dementia Praecox	12
Unclassified	10
Const. Psych. Pers. with Psychosis	6
Alcoholism	5

Many of these cases have come into the hospital in acute excitements, requiring considerable care. As soon as the diagnosis is possible, they have been sent to Washington for continued treatment. This presents many seemingly unnecessary hardships. The very fact of sending an acutely psychotic person 400 miles in itself should be sufficient contra-indication. Difficulties in getting transportation aggravate the problem, because it often makes necessary holding the psychotic patients in the brig or strong room for several days. It is to be strongly recommended, at least for the duration of the war, that acutely psychotic persons be hospitalized at the nearest state hospital. This would enable modern standards to be more nearly maintained.

** Not in accord with impression of author.

A number of articles have been written, especially one by Hoffman,[4] calling attention to the large number of acute cases of short duration occurring in the military. We have seen a number of such cases. We have always seen these cases in consulting practice and raise the query as to whether the apparent new factor is not due to the fact that state hospital psychiatrists tend to see the more protracted and malignant cases, and do not see as many of the short, relatively benign cases.

When we arrived at the hospital we found a certain number of seasick persons on our ward and one of us has made an extended study of this, to whose publications those interested are referred.[5] It is a fact that a certain number of the seasick persons appear to be either neurotic or constitutional inferiority cases. Therefore, there would appear to be as much an occasion for putting them on an N. P. service as elsewhere.

We call attention particularly to the large number of No Disease diagnoses. This is due to the fact that a large number of behavior disorders are seen following some sort of an emotional outbreak or conflict which upon investigation appeared to be a more or less normal reaction to an abnormal situation, and which we did not feel justified giving a psychopathic diagnosis.

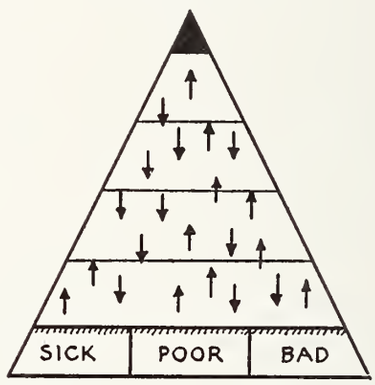
The small number of feebleminded cases is also noteworthy. We are unable to say whether this is due to the fact that these are excluded at the recruiting or training stations, or whether they are not a serious problem in the Navy. We are informed by Dr. C. Stanley Raymond, the Superintendent of the Wrentham State School,** that he has a very large number of his former patients in the military service, "most of whom are doing very well." Here again, is a fertile field for investigation. With a little more liberal use of pschometrics, a few of our constitutional inferiority diagnoses might have been called feebleminded. It has been suggested that the feebleminded problem in the Navy does not come to the attention of the medical service, but is handled by line officers.

** Not in accord with impression of author.

III. *The Composition of Society.*

During the last few years, medicine has been weighted on the organic side and the attention of physicians has been conditioned to detect all sorts of physical and chemical anomalies in the human body. Doctors have not been similarly conditioned to detect mental diseases and peculiarities. Though basically individuals have a great deal in common, a most cursory glance at the composition of society shows stratification, that is, every individual has a status in society determined by the capacity of his body and mind to function. It makes little difference to the armed forces why he does not function, so an exact diagnosis is not necessary.

CHART NO. 2



THE CONE OF SOCIETY

Indicating the tendency of good organisms to function successfully and poorer ones to fail, leaving a sedimentary mass at the base who are considered unfit for service.

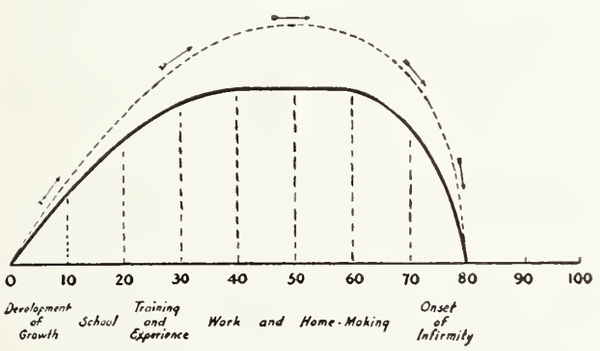
At the present time there are two trends in medicine which are somewhat in conflict. The one group is looking for some test or trick by which a diagnosis can be made. This is all right where such a trick is available, but in most cases, and especially in nervous and mental disease, we are often limited to interpretation of behavior for diagnosis. One question, "What have you been doing lately?" if followed skillfully by clues often does more to bring to light mental disease or defect than all the tests which have been devised. The other group feel that the best method of predicting the future behavior of an individual is an analysis of his past behavior.

IV. *The Trajectory of Life.*

Human behavior is dependent upon a number of factors. A healthy child is born with certain instinctive drives which furnish the motivation for its behavior largely on a physiological basis. As a child grows older and goes to school, he is taught certain conventional things, but above all, he is subjected to social pressure which tends to mould his behavior into conventional patterns. As he reaches adult life, if he is healthy and reasonably intelligent, some degree of control is exercised through factors which may be called wisdom. If all of the aforesaid factors proceed normally, we have a conventional pattern of conduct throughout life.

Life itself is a continual registration of success or failure. Any departure from the conventional norm in the life trajectory is significant as it furnishes a clue to inadequacy of any sort. The height and extent of the curve is not so important as its consistency.

CHART NO. 3



The Trajectory of Life

Illustrating the conventional pattern of life the heavy line with a flattening off during adult life is perhaps more usual.

V. *Significance of the Social Status of the Individual as Indicating Inadequacy or Incompetency.*

Most of the factors which make for success or failure in life cannot be subjected to objective measurement. A superficial study of those elements tending to make for effective function in society would show the presence of health, intelligence, industry, virtue, and attractiveness. It is very difficult to estimate the presence of these qualities in a cursory examination. However, their effect is readily found in a man's social status. While many persons with considerable physical disease and a healthy mind can get along in society, mental disease or defect or peculiarity is very disabling. We rarely find persons who are definitely recognized as insane or feebleminded who are also making a living. The neurotic frequently earns a living and is the most difficult to detect. The drug and alcohol addicts are practically always handicapped socially, and the concept of a personality disorder is purely behavioristic. The diagnosis is usually made on the basis of social status, at any rate, on the basis of behavior.

In a previous study an attempt was made to compile a census of the handicapped people in Massachusetts and the result was as follows:

TABLE NO. 3

Partial Census of Handicapped People in the State of Massachusetts.

Population of Massachusetts (1940):	4,316,721
Aided by Private Charity:	1,743,863
Aided by State and Towns:	631,556
Aided by Boston Community Chest (1940):	400,000
W. P. A.	82,000
Arrests (1939):	209,343
Admitted to Penal Institutions (1938):	15,000
Under care of Veterans' Bureau (1940):	17,104
Department of Mental Health (1940):	26,000
Estimated incidence of Feeblemindedness 2%:	86,000
Estimated Sick with Chronic Disease:	500,000
Estimated Disabling Physical Defects 3.1%:	124,000
Admissions to Hospitals (1940):	424,951

It is obvious that if all these persons are handicapped they all require special scrutiny before being admitted to the military. For many years one of us has been using a mixed medico-social classification of handicapped persons which has been of help in roughly predicting future careers.

TABLE NO. 4

Categories of Handicapped Persons.

The Child
The Aged
Handicapped Classes
The Insane
The Feebleminded
The Neurotic
The Disordered Personalities
Drug and Alcohol Addicts
The Physically Diseased

VI. *Initial Contact at Recruiting Station.*

Here is the most important place in the Navy if one has in mind effective application of psychiatry to the whole problem. There is abundant evidence that it is possible to state the psychiatric problem of the Navy in terms of good or bad recruiting. We suspect that very little is being done at recruiting stations at the present time to detect nervous and mental incompetency. This suspicion is based upon conferences with many medical officers who are on recruiting duty and upon the obvious defects who could never have been passed if any scrutiny had been given the personality. Many suggestions have been made recommending short, trick examinations by which nervous and mental disease could be detected. In the opinion of the authors it is folly to call a three-minute interview a psychiatric examination. It is equally fallacious to suggest that psychiatrists be placed at all recruiting stations. However, there is a method by which very good results can be obtained. A number of things militate against this. In the first place, the great hurry and rush is inevitably wasteful. Medical officers complain that line officers rebuke them for inquiring into the personality of the applicant. One physician stated that one line officer told him to do his physical examination and he would do the recruiting, looking upon this type of questioning as an interference. They all have the same story of domination by line officers in the hurry and zeal to get large numbers of recruits. If this is necessary one might ask, why examine them at all? Why not recruit every applicant and send them to a training station. One is driven to the following conclusion, namely, whereas the military authorities are sold to the importance of physical defects, they are not yet convinced of the malignancy of nervous and mental defects. If a man looks healthy, in he goes regardless of whether he has dementia praecox. A few cases will speak louder than much argument.

K. A. Age 19. Committed to a state hospital in 1941 where he spent a year. Had insulin shock treatment and was discharged on visit in August, 1942. Three weeks later he enlisted in the U. S. N. In Class 4-F in the Draft at the time of enlistment because of mental disease. Interviewed by psychiatrist who asked him how much he went to school and if he was ever self-conscious, but did not ask him what he had been doing for the last year. Deserted shortly after enlistment.

F. T. Age 32. For many years had been drifting about the country as a bell boy, entertainer in night club and various other odd jobs. No fixed abode. Aggressive homosexual since adolescence. Awaiting court martial for irregular sexual practices.

D. N. Age 23. At 14 years of age was committed to a reform school which he had been in and out of through minority. No regular employment. Working here and there, especially at carnivals. Two commitments to state hospitals for observation. Deserted shortly after enlistment.

I. C. Age 20. Committed to Training School in 1933, still on parole. A persistent run-away, described by the chief of police as the worst man in town. Deserted soon after enlistment.

M. R. Age 36. Had 8 separate commitments to hospitals for mental disease with 8 different diagnoses. Probably manic depressive. No regular employment. Deserted shortly after enlistment.

L. Y. Age 37. Committed to school for feebleminded shortly after birth. He has been an inmate of three different schools for the feebleminded during most of his life. Sent to hospital because when he tried to study higher mathematics in a school it made his head ache.

R. E. Age 19. Although he went to school until he was 16 years old, unable to read and write. Sent to hospital because at the time of his trial for running away, he appeared to be dull and he was found to be grossly feebleminded.

C. Y. Age 41. Bad conduct discharge from the Navy following the last war, a persistent claimant for pension since then, claiming total disability. Seventy-five arrests in metropolitan Boston for drunkenness and minor crimes. Committed as insane to the Boston Psychopathic Hospital; Worcester State Hospital; Medfield State Hospital; St.

Elizabeth's Hospital, Washington, Springfield State Hospital, Maryland. Sent to hospital complaining of stomach trouble a few days after enlistment. Called constitutional psychopathic inferiority without psychosis.

B. Y. Age 20. A social problem since early childhood; an inveterate thief and forger and frequent run-away. Discharged from the U. S. Marines in June, 1942, having attempted suicide with gas in a lodging house in Brooklyn. Shortly after he enlisted in the Navy. Wanted in three states for forgery. Sent to the hospital because he ran away. Surveyed as a constitutional psychopathic inferiority.

K. R. Age 31. A roustabout and chronic drunkard for many years. Separated from his wife. Irregular employment. He was on a drunk when he enlisted and deserted shortly after.

The time-honored alibi used to excuse the recruiting of such cases is that there is not time for a psychiatric examination. It takes but a moment for a trained eye to see the difficulty in such cases, so time is not the problem. A good case worker would interview several hundred applicants a day and pick out the bulk of such social problems.

TABLE NO. 5

Fields of Inquiry in Determining Social Status of Individuals.

A. APPEARANCE	1.	2.	3.	4.
B. HOME	1.	2.	3.	4.
C. SCHOOL	1.	2.	3.	4.
D. OCCUPATION	1.	2.	3.	4.
E. MARITAL	1.	2.	3.	4.
F. HEALTH	1.	2.	3.	4.
G. BEHAVIOR	1.	2.	3.	4.

VII. *The Application of Psychiatry to the Training Station.*

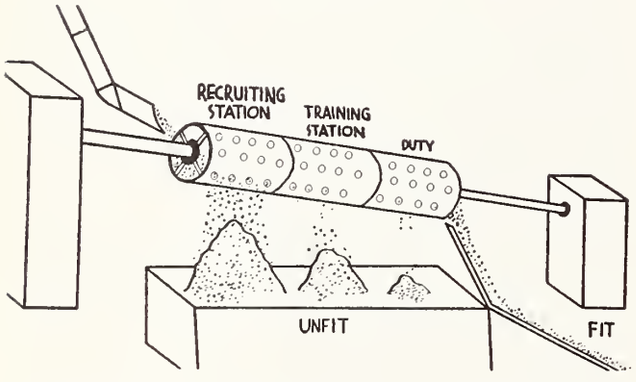
This matter was reviewed at some length by one of us during and following the last war. To summarize, each man should have an initial interview. This can be done quickly if the persons doing it have had training in psychiatry. However long one has practised psychiatry in a state hospital, he has not had the sort of experience which screening naval recruits requires. This is a specialty in itself. The method used by one of us was as follows: Each individual was interviewed briefly, the interview averaging less than two minutes, and could be geared down to less than one minute if necessary. It should be emphasized that this interview is not a psychiatric examination but a method of selecting those whom we wish to later examine more thoroughly. Social criteria were investigated and the less than 10 per cent who had something in the pattern of their life suggesting incompetency were held out. In many groups this number was less than 5 per cent. These individuals were held and thoroughly investigated by social service and further study, and either sent on to duty or discharged as was recommended. From our recent experience we have seen a number of cases who have been through training stations, have been studied by psychiatrists, and optimistically sent to duty. This could mean but one thing, the psychiatrists had not had experience with the malignancy of certain patterns of behavior.

VIII. *The Appearance of Psychiatric Handicaps in the Various Phases of Naval Service.*

When the individual has been recruited, passed through training and is assigned to duty, he then comes to the real test of his competency. As in civil life, incompetent persons may be roughly classified as the sick, the poor, and the bad, that is, individuals who have psychiatric handicaps appear in the sick bay, or are incompetent in their work, or are disciplinary cases. It would seem obvious that such cases, especially if their difficulties appear to be chronic, should be scrutinized by psychiatrists. It is astonishing how long medical officers will listen to chronic complaints without suspecting seriously handicapping neuroses, especially such complaints as backache and indigestion. Doctors frequently suspect malingering but do not seem to be equally alert in detecting social problems and psychoneuroses. It is also astonishing how long disciplinary officers will try to break the wills of defectives, really entering into a struggle to see which one will wear the other out. Likewise, incompetency is tolerated again and again, and our experience has been that sooner or later such in-

dividuals are going to be eliminated from the Navy. It is much better to eliminate such a person forthwith than to transfer the unfit onto someone else's shoulder as is so frequently done. If such individuals come in the category of the sick, they will sooner or later be hospitalized. They are very apt to be operated upon and may become eventually permanent charges upon the government. If their trouble is incompetency, they will sooner or later become discouraged and either desert or develop physical symptoms and be hospitalized. The disciplinary cases do little service, frequently running away, filling the brigs, and are a plague spot in naval service.

CHART NO. 4



Illustrating a Principal in All Sifting Processes: namely, if it is done thoroughly in the first instance, there is a decreasing amount of residue in later siftings.

IX. *The Elimination of the Unfit Following Failure to Make Good in the Service.*

Much time and thought has been given to the protection of the government from illicit pension seekers. A good deal of this has had to do with the method of discharge. This matter may well be left with the Veterans' Bureau who may be assumed to be as competent as the military officers. The law definitely puts the matter of compensation upon the Veterans' Bureau and if medical officers do their work well, amassing all the facts, then stating them clearly, they need not be concerned with what happens after discharge because this is a function of another government agency. No decision should be made in the medical survey which is not supported by evidence.

We have been somewhat surprised to find the extent to which military medical officers are trying to evaluate the capacity of individual psychiatric cases. We had supposed that it had long since been settled that this was done entirely upon an actuarial basis. When a man is rejected for life insurance because he has a heart murmur, the physician so doing does not predict that he will die sooner than the man without a heart murmur, but he does say that in a large number of cases the man with the heart murmur is a poorer risk than one without. Therefore, he is not accepted. Likewise, when an ex-reformatory inmate or a mild neurotic is rejected by the Navy or discharged, it is not presumed to predict that, he as an individual, will not make a good sailor. The action is taken upon an actuarial basis, namely, that with 1,000 or 10,000 cases, the ones with N. P. disabilities are rejected because as a class they present less chance of success and greater chance of failure. We have seen many cases returned to duty from other stations or hospitals in the fond hope that they would make good. Insofar as we know, there is no way of accurately predicting the future behavior of an individual. The best we can do is to eliminate those whose disorder is of such a nature that they present relatively poor risks. It is proverbial that line officers are inclined to send their disciplinary problems to hospitals whereas it would perhaps be better if they were discharged directly.

Those who do not succeed in carrying out the conventional patterns of conduct required by the Navy may roughly be classified as the sick, the poor and the bad. These three groups embrace the socially incompetent. It appears to us that these categories might well be applied to the Navy procedure, especially in the matter of discharges. Those who come to the attention of the Neuro-Psychiatric Service tend to be found unfit for the military service. With 7 per cent of the admissions, we have had 54 per cent of the surveys on the N. P. Service. After a satisfactory case history has been worked up and a diagnosis has been made, the following procedure would seem appropriate:

1. If the case appears to be weighted on

the side of sickness, that is, if insane, feeble-minded, definitely psychoneurotic or grossly psychopathic, the individual should have a medical survey and be given an honorable discharge on medical grounds.

2. If the individual appears to be incompetent, and if this incompetency is not explained by fairly definite nervous or mental disease, he should be recommended for an inaptitude discharge.

3. If the principal difficulty is in the field of delinquency and no gross nervous or mental disease is found, an undesirable discharge would seem appropriate.

There will, of course, be intermediary and overlapping cases which can be handled on an individual basis. However, the great run of cases somewhat readily fall into the above groups. If some such procedure could be agreed upon, it would facilitate matters a great deal and we would be able to handle cases much more expeditiously.

Finally, the period during which the process of discharge is being worked out is very important as concerns morale. Failure in the Navy, for whatever cause, is a disappointment to the men, and all sorts of defense reactions are built up to cover their disappointment. A great deal of time is necessary to soften these depressive ideas and get them in a mood where they feel they have done the best they could, that there is nothing ignominous about a medical discharge, and they should go back into civil life with their chins up and faces toward the east. They should be looking forward to a career to which they are better fitted, and not to the fond and futile hope that a pension is in itself a satisfactory goal.

TABLE NO. 6

Principle Diagnostic Groups showing percentage which were considered to have existed prior to enlistment.

	Total	*EPTE*
Neurosis	121	57%
Personality Disorder	73	100%
Alcoholism	49	12%
Epilepsy	43	42%
Insanity	42	50%

X. *Summary.*

1. An analysis has been made of 500 neuro-psychiatric admissions to a naval hospital.

2. The amount of psychiatric disabilities in the Navy bears a direct relation to the quality of recruiting.

3. During the past year there appears to have been very little effort to detect those applicants with neuro-psychiatric disabilities.

4. Properly organized and staffed, it is relatively easy to detect, and so eliminate, those applicants with neuro-psychiatric handicaps.

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*The Use of Sulfa Drugs in Traumatic Surgery**

By Francis Winchenbach, M. D., Bath, Maine

The miracle of the sulfonamides has been given world-wide acclaim.

The systemic use of the drugs is rather definite but in its local application there seems to be some confusion in the minds of the average physician. Rightly so, too, because to date there is controversy even among the experts.

A review of the experiences of others has been made and an attempt to clarify and unify the local therapy is the purpose of this presentation.

In traumatic surgery there are cardinal principles to be followed before sulfonamides are even considered and two of these principles, debridement and hemostasis, are paramount.

The diffusion and absorbability of sulfonamides in the presence of dead tissue is negligible and ineffective. Adequate debridement therefore *must* be performed.

Assuming then that the wound is properly prepared the choice of sulfonamide and its dosage is considered. Let us first consider the choice of drug and reasons for that choice. If the tissue removed has been examined bacteriologically and the invading organism known the choice is easier.

It has been established that:

1. Sulfanilamide is more effective against the streptococcus.
2. Sulfathiazole is the drug of choice in the staphylococcic infections.
3. Against the coli-group sulfanilamide and sulfadiazine are most effective.
4. As for the gas forming organisms sulfathiazole again is the choice but necessarily with antitoxin and complete excision of devitalized tissue.
5. All must be augmented by oral sulfonamide therapy to be of greatest value.

As for toxicity to patient the rating is:

1. Sulfanilamide.
2. Sulfathiazole.
3. Sulfadiazine.
4. Sulfapyridine.

It may be concluded then that for prophylaxis, organism unknown, that sulfathiazole is the best all around drug of the group.

As for dosage:

The Roosevelt Hospital recommends 8 gms intraperitoneally and 4 gms in the wound.

The Massachusetts General Hospital gives 5 mgm as a maximum intraperitoneally and this amount seems to be more generally used.

In wounds the National Research Council suggests 1 gm to 10 square inches of surface be applied by dusting on the area.

The manner of application has two generally used procedures:

That of simply dusting on the surface, used most by our service branches, and the method advocated by the English (Colebrook & Francis) of dusting the powder on the surface, covering with wet saline compresses and sealing with an ointment.

There seems to be no question that the sulfonamides are bacteriostatic and toxin inhibitors but no proof has been advanced to date that the drugs either neutralize or activate preformed toxin.

In conclusion, it is definitely established that sulfonamides locally, combined with proper debridement and augmented by oral therapy have a very definite place in traumatic surgery.

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* Read before the meeting of the Maine Medical Association at Poland Spring, Maine, June 22, 1942.

Editorial

Physicians Must Volunteer from Larger Cities

Young available physicians in the large cities of the country, particularly in those of the eastern seaboard, whose failure to volunteer has caused a lag in the procurement of medical officers for the armed forces, should be called before the bar of public opinion, *The Journal of the American Medical Association* for March 27 declares in an editorial. *The Journal* says:

"At a recent meeting in Washington of the Directing Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians with the Officer Procurement Service of the United States Army and with representatives of other governmental agencies, evidence was clearly set forth that the procurement of medical officers for the armed forces is lagging. The responsibility rests unquestionably on the failure of young available physicians in the large cities of the country, particularly those of the eastern seaboard, to volunteer. Officers of the medical societies of New York, Massachusetts and Connecticut were present and the situation was placed before them. The rural areas of the United States have contributed doctors not only up to such quotas as were assigned to them but in many instances well beyond these quotas; it is simply impossible to anticipate that they will make a further contribution at this time. In the meantime, New York, Brooklyn, Boston and some of the larger communities in the states of Connecticut, New Jersey, Pennsylvania and California have failed even to approximate their quotas.

"The needs of the armed forces for physicians during 1943 are well defined. The number of physicians to be expected from recent graduates, internes and those now holding residencies has been determined. Beyond this number at least six thousand more physicians must come from the civilian population. The Procurement and Assignment Service for Physicians, Dentists and Veterinarians has devised a technic which involves, first, a determination of the availability of the physician concerned or his essentiality for any civilian position which he occupies; second, notification of the physician of his availability and a request that he appear before his local procurement board; third, a notification of the Selective Service Board of the fact that the physician concerned is considered available and that he has failed to volunteer. Thus far pressure beyond this has not been exercised. There remains, however, the mobilization of the pressure of public opinion.

"In some instances physicians have declared flatly to representatives of the Procurement and Assignment Service and the Officer Procurement Service that they do not wish to volunteer and that they will not volunteer. When it is known to other physicians in the community that a physician under 38 years of age, declared available by the Procurement and Assignment Service, refuses to volunteer in this time of the nation's need, when many an older physician, frequently with innumerable obligations, has given up his home, his practice and the responsibilities of years to participate in this war, the public has a right to know that the younger physician is not willing to do his part. Certainly the Procurement and Assignment Service should consider the possibility at this advanced stage of the war effort of making public through the state medical journals not only the names of those who are already participating in the war but also the names of those who have been declared available and have not themselves ever indicated a willingness to participate. Let them be called before the bar of public opinion!"

Maternal and Child Welfare

Immunizations and Specific Therapy in Common Contagious Diseases

The infant of today in entitled to protection against contagious diseases. The physician should insist that he be immunized against diphtheria and small pox, as these procedures are of proven value. There is enough evidence in favor of Sauer's pertussis vaccine to justify recommending it highly. The earlier these immunizations are done after six months, the less severe are the reactions. The parents' fear that the infant is too young are without foundation.

A good routine procedure is as follows: at six months give Sauer's pertussis vaccine, double strength, one, one and a half, and one and a half cc. at two-week intervals, a total dose of eighty thousand million killed bacteria. In a good many there will be a moderate reaction. The infant may refuse part or all of his evening meal, be somewhat restless, and have a fever, usually not severe. There is likely to be some local reaction. By morning he is usually well. No treatment is needed. The reactions occur after the first or second inoculation, very rarely after the third. It is a small price to pay for protection against a serious disease. Immunity comes on in about four months. It has been suggested that one yearly injection thereafter may result in permanent immunity. Unfortunately, the parents are likely to forget it after a few years, with the result that the immunity is likely to end when the child is in high school or college, a very poor time to have pertussis. Sauer's vaccine is of no use to the exposed child, nor is any other vaccine of proven worth. For the treatment of pertussis no specific is of proven value. There have been good reports of antitoxin (rabbit) but it is very expensive and its efficacy is not yet proven.

At nine months, give alum precipitated diphtheria toxoid, two or possibly three doses of 0.75 cc. at intervals of three weeks or longer. At this age constitutional reactions are rare. Locally, there is some soreness and an induration which persists for some time. If tetanus alum precipitated toxoid is combined with the diphtheria, the dose is one cc. at three-month intervals for two doses. Reactions are more severe. All of these doses should be lessened for older children or adults. A Schick test should be done six months after the last inoculation. Test again at six and twelve years. It is a waste of time to do a Schick test on non-immunized small children.

Vaccinate at one year (or at any age during an epidemic) on the arm, as reactions are less severe than on the leg. The scar with modern technique is inconspicuous. Place a drop of the vaccine near the insertion of the deltoid. With a sharp needle puncture through it into but not through the epidermis, holding the needle almost parellel with the skin. No blood should be drawn. Cover the area until the next day lest the infant, by scratching, inoculate himself elsewhere. When the vaccination takes, use no shield or other occlusive dressing. If a gauze dressing is used, be sure that the adhesive does not encircle the arm. Post-vaccinial encephalitis does not occur under three years. Vaccinate again at six and twelve years.

Under ordinary circumstances, it is unnecessary to immunize against typhoid. Active immunization against scarlet fever is unreliable. It takes five inoculations, which are followed by severe reactions. It is not recommended for routine use, nor as a public health measure.

Measles will not attack an infant under six months of age, and under one year the disease is apt to be mild. The older exposed child may be treated with ten cc. of convalescent serum, or four cc. of placental globulin, human, intramuscularly on about the sixth day after exposure, which is usually the second day after the exposing child breaks out with the rash. This may produce a

modified attack. Treatment immediately after exposure may prevent the disease, but the immunity lasts only a short time. Modified measles cannot be trusted to produce as lasting immunity as a full-blown attack. Results of treatment may be — a, failure; b, failure after a prolonged incubation period (common); c, modified measles; d, complete, but temporary, protection. Since then, we have less than an even chance to produce the desired result, modified measles, and since the immunity from modified measles may not be permanent, it hardly seems worth while to use the procedure except in debilitated children, especially now that the sulphonamides are such a good weapon against complications.

The use of scarlet fever antitoxin after exposure is often disappointing. All too frequently the disease comes on just the same after a prolonged incubation period. The author has abandoned its use for this purpose. For treatment of a severe case, it is well worth using. Opinions vary as to the efficacy of sulphanilamide in scarlet fever. Probably it has little effect on the disease itself but lessens complications. In the presence of otitis it should be used, if at all, with great vigilance lest it mask the symptoms of mastoiditis. Some believe it is contra-indicated in the otitis of scarlet fever.

Antimeningococcus serum or antitoxin may be used in epidemic cerebrospinal fever, but not intraspinally. Late reports indicate that sulphonamides alone are more effective than a combination of serum and the drug. Do no lumbar puncture after the first diagnostic one except for the relief of headache from pressure.

Tuberculin testing should be done more than it is. The Vollmer patch makes a simple, painless, and reliable test. The patch is applied after cleaning the skin with acetone, and allowed to remain forty-eight hours, keeping it dry. Two days after removal, the area is examined for erythema at the site of the outer squares. A reddened area under the entire patch occasionally occurs. This is due to sensitivity to adhesive and should not be confused with a positive test, which is localized to the area under the outer squares. Remember that a positive test does not necessarily mean active tuberculosis, but only that at some time the child has been infected. In the case of a sick child it does not prove that the present symptoms are due to tuberculosis. It does show that the child should be carefully watched, especially at high school age. Periodic X-rays are indicated in all children with a positive tuberculin test.

Your Committee on Maternal and Child Welfare.

(From "Present Status of State Cancer Control Programs," Leonard A. Scheele, Past Assistant Surgeon, U. S. P. H. S. Bulletin, Amer. Soc. for Control of Cancer, vol. 25, No. 2, page 18, Feb., 1943: Reprinted from Public Health Reports, Oct. 23, 1942).

"Current cancer control activities conducted by 39 health departments and three cancer commissions in 38 States and the Territory of Hawaii have been summarized."

"Activities consist of lay and professional education, provision of diagnostic and treatment facilities, and research, primarily statistical."

"Interest in cancer control has increased rapidly in the past few years and most of the new programs have been developed since 1930. It seems likely that worthwhile gains in the fight against cancer will come through improvement and extension of current programs. Later, when our knowledge of the cancer process increases, it is hoped that the program can be improved to make it even more effective and that some day it may be primarily a preventative rather than a curative one."

Case finding in tuberculosis is a costly procedure but when measured against the estimated monetary losses caused by the disease, the expenditure for the discovery of cases seems relatively small.—H. R. Edwards, M. D., el al, *Milbank Memorial Fund Quarterly,* Oct., 1941.

Correspondence

April 16, 1943.

Frederick R. Carter, M. D.,
Secretary, Maine Medical Association,
Portland, Maine.

Dear Doctor Carter:

Re: Chapter 358, Public Laws 1943, Requiring Venereal Disease Patients to take Treatment, and Physicians to report the cases.

This became law April 9, 1943. Forms are being prepared and will be forwarded by the Bureau of Health to all Maine physicians. From then on the law will be enforced. For failure to report when and what the law requires, physician is liable to fine or imprisonment or both. For reporting more than the law requires, he might be liable to legal action by the patient.

Venereal disease is a "contagious or infectious disease of a disgraceful kind." To impute that another has it is libellous per se, i. e. law suit is maintainable without proof that the plaintiff suffered actual damage from the statement. And truth is not an absolute defense although it may be shown in reduction of damages. To state a truth with malice may be libel. And malice may be inferred from the circumstances.

Libel suit is not maintainable, however, if the statement is "privileged." "A report furnished within the requirements and spirit of a statute would doubtless be regarded as privileged." But a report, oral or written, "not in obedience to a statute," is not so privileged.

Many persons believe the statement of patient to physician is secret and "privileged." Not so in Maine. The ethics of the medical profession require the physician to keep inviolate his patient's disclosures. But only until the law compels otherwise, as it does here. The compulsion of a public health law designed to protect society overrides the ethics of the profession.

Consequently, the Maine physician must now take care to follow an exact course. I indicate below that course as I see it.

First, physician makes a record of his venereal disease case by number, name and address within 48 hours after he determines the case to be such.

Second, he reports to the Bureau the case within 48 hours stating age, sex and color of the person infected. Form therefor is furnished by the Bureau bearing the number assigned by the Bureau.

But if the patient is receiving 1.) treatment in a clinic to which the Bureau contributes or 2.) drugs, hospitalization, therapy furnished by the Bureau, then name and address must be reported also.

Third, if the patient "fails to observe the necessary precautions indicated in the treatment," the physician must take note thereof and "at once" submit the name and address of the patient to the Bureau.

I suggest that particular care be taken in 4 connections:

1.) To report name and address of the patient "at once" where "the necessary precautions indicated in the treatment" are not observed by the patient. If, for instance, a patient told to return for treatment does not appear as directed or within a short reasonable time thereafter, the physician must under penalty of fine or imprisonment or both report the name and address. Look over the treatment cards of the patients. Are they coöperating? If not, report name and address.

2.) Do not report name and address except as the law requires. To so report except "in obedience to the law" may cause vexation and law suits despite the provision in the law that the reports "shall be confidential."

3.) The law states that the patient must be "known by said physician to have" the venereal disease. Presumptive diagnosis is not necessarily actual knowledge. To substitute the one for the other might spell civil action by a disgruntled patient.

4.) The Bureau may construe its right to investigate under Section 38 of the law, to authorize its inspectors to examine the case records of patients in physicians' offices. If by opinion of the Attorney General, Section 38 gives that power, I will advise you. Then doctors are compelled by law to open such records despite ethical considerations.

In conclusion. Physicians are jealous to protect the confidential statement given them by patients. They respect the ethics of their profession. And they must take care to protect themselves against law suits by offended patients. But the profession will want to comply with the letter and spirit of this law, must do so. I suggest that the law, copy enclosed, be printed in the Journal. If the physicians will follow the suggestions herein contained, I believe they will comply with the law, observe such ethical requirements as remain effective in view of the law, and protect themselves from civil liability to patients. If the law (which follows) and the above explanation give rise to questions, I will gladly answer them to the best of my ability.

(Signed) HERBERT E. LOCKE.

HEL/mt
Enc.

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED FORTY-THREE

Public Laws 1943, Chapter 358

AN ACT Relating to Infectious and Communicable Diseases.

Emergency preamble. Whereas, a state of war exists between the United States and Germany, Italy, Japan and other foreign countries; and

Whereas, in the judgment of the legislature this fact creates an emergency within the meaning of section 16 of Article XXXI of the constitution of Maine and requires the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

P. L., 1933, c. i. Par. 37, 38, 39 amended, and par. 39-A added thereto. Sections 37, 38 and 39 of Chapter I of the public laws of 1933, as amended, are hereby repealed and the following sections enacted in place thereof, and section 39-A added thereto:

"Sec. 37. Definition; duties of physicians and officers of institutions; reports of state bureau of health. Syphilis, gonorrhea, chancroid, and lymphogranuloma venereum are hereby declared to be infectious and communicable diseases, dangerous to the public health.

"Every physician in the state, within 48 hours of the time the fact comes to the knowledge of said physician, shall report in writing to the state bureau of health, any person known by said physician to have any of the above diseases, and shall keep a record of such cases by number, and name and address. Such report shall be made on a form furnished and numbered by the state bureau of health, which shall state only the age, sex, and color of the person infected. In case such person having any of the above diseases fails to observe the necessary precautions indicated in the treatment thereof, or in cases where financial obligations for treatment are incurred by the state bureau of health, the name and address of such person shall be submitted at once to the state bureau of health.

"All information and reports concerning persons suffering with venereal diseases shall be made on forms furnished and numbered by the state bureau of health, shall be held confidential, and shall not be available to any person not an agent of the said bureau, or for any other than a public health purpose.

"The chief officer having charge for the time being of any hospital, asylum, dispensary, jail, sanatorium, or other similar private or public institution in the state, shall report in like manner any cases of the aboved-named diseases which come into his care or under his observation."

"Sec. 38. State bureau of health may require examination; limitation. The state bureau of health is hereby empowered to make such investigations as may be necessary to ascertain the source of any infectious or communicable disease. Whenever said bureau has cause to believe that any person is infected with any of the above diseases so as to expose others to the dangers thereof, said bureau by its representatives shall petition a judge of the municipal court or a justice of the superior court in the county where said person resides or is found, setting forth said facts and requesting an examination of such person. Said judge or justice may order such notice thereon as he may deem proper for such person to appear and answer thereto. Upon hearing, if said court finds cause to believe that such person is so infected, he may issue an order requiring said person to be examined by a licensed physician, at the expense of the bureau; and use all necessary legal processes to carry its decrees into effect."

"Sec. 39. Bureau to supervise cure of disease. It shall be the duty of said bureau when the report in section 37 or the examination in section 38 reveals that such person has any of the above diseases and has not consulted a physician or has not taken the necessary treatment to place such person immediately under medical treatment in order to effect a cure. Such treatment shall continue until, in the opinion of the attending physician, the cure of said disease has been effected, or is rendered non-infectious.

"Nothing in the provisions of sections 37 to 39, inclusive, shall be construed as denying to any person the right to be examined or treated by a licensed physician of his own choice."

"Sec. 39-A. Penalty. Any person who violates the provisions of sections 37, 38 and 39 shall be punished by a fine of not more than $100, or by imprisonment for not more than 11 months, or by both such fine and imprisonment."

Emergency clause. In view of the emergency cited in the preamble, this act shall take effect when approved.

(Approved April 8, 1943)

Legislation of Interest to Physicians Offered at 1943 Maine Legislature and Action Thereon

The following were enacted and bear the Chapter number in the Public Laws of 1943 indicated below.

1. Chapter 236—An Act Relating to Procuring or Attempting to Procure Abortion or a Miscarriage. As originally proposed, it abolished numerous distinctions in the Revised Statutes, repealed the requirement that the woman involved be pregnant, increased the penalty, substituting mandatory imprisonment in place of fine or imprisonment in the discretion of the court. Reason: prosecuting officers find it difficult to convict in such cases. Objection: no person should be convicted unless at least the woman was pregnant, the old provisions of the statute have stood the test of time, and cases of alleged abortion occur in which it is desirable that the court have discretion. My particular interest: that doctors are often accused by the principals to avoid prosecution themselves. Result: all objectionable features removed. Law as enacted simply makes the penalty fine *and* instead of *or* imprisonment. The court may, however, still use its discretion and probate the sentence. So there is, practically speaking, no change in the law. Becomes law July 9, 1943.

2. Chapter 358—An Act Relating to Infectious and Communicable Diseases (the Venereal Disease Report Bill). An analysis of that law and suggestions concerning conduct of doctors under it I have previously made. In general, it requires the report to the State Bureau of Health of patients found to have venereal disease under certain circumstances previously explained. Became law April 9, 1943.

3. Chapter 273—An Act to Authorize and Provide for the Temporary Admission to Practice in this State of Physicians and Camp Physicians to Protect the Health of the Civilian Population During the War Emergency Period. Permits admission to practice "during the war emergency period" of physicians "licensed as such outside the state" if the state board of registration "finds them qualified," the board imposing restrictions and area limitations on such practice. Also permits licensing by the board of Class A physicians for "not longer than 10 weeks during the summer months" to "care for the campers in the particular camp for which he (the physician) was hired," practice "outside the limits of said camp" or to others not connected with it being forbidden. Became law April 9, 1943.

4. Chapter 63—An Act Relating to Fees of Expert Witnesses in Homicide Cases. Provides that "the expenses of all expert witnesses at the trial of homicide cases shall be paid by the state." Avoids difficulty heretofore experienced in dealing with county authorities who some times are reluctant to pay these bills. The Joss case in Sagadahoc County recently is an illustration. Becomes law July 9, 1943.

5. Chapter 321—An Act Relating to Medical Examiners. Of interest chiefly to medical examiners. Provides that if "the body, when found, is in imminent danger of being destroyed . . . or carried away . . . or lost in any body of water, any person may take steps for its preservation awaiting the arrival of authorities; but if no such danger exists, the body shall not be moved until photographs, measurements, drawings, etc., are taken." Becomes law July 9, 1943.

6. Chapter 83—In case artificial limbs, eyes and teeth in use by an employee (who is awarded compensation under the Workmen's Compensation Act) are injured or destroyed, the employer shall repair or replace them. Becomes law July 9, 1943.

7. Chapter 251—An Act Relating to Pre-marital Medical Examination. Adds "any doctor of the Armed Forces or any laboratory of the Armed Forces, or state laboratories of other states" may furnish acceptable reports for pre-marital exam. Also waiver may be granted by *Judge of Probate* as well as Superior Court judge. Becomes law July 9, 1943.

8. Chapter 265—Repeals the provision for commitment of persons of unsound mind to state hospitals for observation which was Section 414 of Chapter 1 of the Public Laws of 1933, the revised Health and Welfare law passed in 1933. Becomes law July 9, 1943.

9. Chapter 21—An Act Amending the Charter of the Associated Hospital Service of Maine. Adds medical and surgical service to the Blue Cross plan. "The private physician-patient relationship shall be maintained under all medical service contracts and the subscriber at all times shall have free choice of a physician. The provision for medical service, or medical expense indemnity, shall be based upon definite agreements covering medical or surgical care provided through duly licensed physicians in their offices, in hospitals, and in the home, without discrimination against schools of practice of the healing arts, and for nursing service and necessary appliances, drugs, medicines, and supplies. Medical services shall not be construed to include hospital services." Becomes law July 9, 1943.

Note the provision "without discrimination against schools of practice of the healing arts." The intention is to provide for patients choosing osteopathic hospitals and "osteopathic physicians." The Blue Cross, proponents of the bill, stated that they did not wish the charter unless it would include osteopathic hospitalization and treatment by osteopaths as well as by M. D.'s.

10. Chapter 283—An Act Relating to Appropriations for Private and Public Hospitals for Medical Treatment. "Administration of appropriations for aid of public and private hospitals. Such sums of money as may be appropriated by the legislature in aid of public and private hospitals shall be expended under the direction of the department of health and welfare, and the expense of administration shall be charged to the appro-

Continued on page 99

COUNTY SOCIETIES

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President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

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President, Thomas G. Harvey, M. D., Mars Hill
Secretary, Clyde I. Swett, M. D., Island Falls

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County News and Notes

Paid-Up Membership for 1943

Piscataquis County Medical Society
Franklin County Medical Society
Aroostook County Medical Society
Hancock County Medical Society
Oxford County Medical Society
Knox County Medical Society
Washington County Medical Society
Androscoggin County Medical Association
Lincoln-Sagadahoc County Medical Society
Waldo County Medical Society

Cumberland

The Cumberland County Medical Society met at the Mercy Hospital on April 9th, at 7.30 P. M. There were forty members present.

The names of D. A. Santoro, M. D., of Portland; and Vincent Gould, M. D., of Brunswick; were submitted and accepted to membership by transfer from the Penobscot County Medical Society and the George Washington University Medical Society. The names of Ernest Folsom, M. D., of Portland; and Waldo Skillin, M. D., of South Portland; were submitted for reinstatement in the Society and were referred to the Board of Censors.

The report of the Meningitis Committee was read and accepted.

The annual report of the Secretary-Treasurer was read and accepted.

The following officers were elected for the present year:

President, J. Calvin Oram, M. D., South Portland.

Vice President, N. B. T. Barker, M. D., Yarmouth.

Delegates to the Maine Medical Association for two years: Clyde Richardson, M. D., Brunswick; R. S. Hawkes, M. D., Portland; William Holt, M. D., Portland; Benjamin Zolov, M. D., Portland.

Alternates: Ralf Martin, M. D., Portland; Oscar R. Johnson, M. D., Portland.

Delegates for one year: Thomas A. Foster, M. D., Portland; DeForest Weeks, M. D., Portland; Frank A. Smith, M. D., Westbrook.

Alternates: Louis L. Hills, M. D., Westbrook; Joseph E. Porter, M. D., Portland.

Committee on Public Relations: Harold V. Bickmore, M. D., Theodore C. Bramhall, M. D., Roderick L. Huntress, M. D.

Legislative Committee: Edwin W. Gehring, M. D., Franklin A. Ferguson, M. D.

Councilor for three years, Roland B. Moore, M. D.

The meeting was addressed by Major John L. Fromer, whose subject was, *Allergy and Its Relation to General Practice.* The paper was illustrated by lantern slides and was discussed by Drs. Warren, Scolten, Oram, Beach, O. R. Johnson, and Babalian.

The meeting was preceded by an afternoon clinic at the Maine General Hospital and was followed by a buffet lunch. At 11.00 P. M., the meeting was adjourned.

EUGENE E. O'DONNELL, M. D.,
Secretary.

Kennebec-Somerset

A joint meeting of the Kennebec County and Somerset County Medical Associations was held at the Elmwood Hotel, Waterville, Maine, on Wednesday, April 15, 1943.

Following dinner, served at 6.30 P. M., the business meeting was called to order by A. J. Gingras, M. D., President of the Kennebec Association. On motion it was decided to dispense with the reading of the minutes of the previous meetings of the two societies. The following were elected to membership of the Kennebec County Association:

Harry Elkins, M. D., Augusta.

Kurt A. Sommerfeld, M. D., Gardiner.

M. Eleanor Blish, M. D., State Health Dept., Augusta.

First Lieutenant John F. Reynolds, M. C., U. S. Army.

Following some timely remarks by Frederick R. Carter, M. D., former secretary of the Kennebec County Association, and at present Secretary of the Maine Medical Association, concerning affairs of the State Association, Doctor Gingras presented George Young, M. D., of Skowhegan, Maine, who gave the address of the evening. In taking up *Some of the Practical Aspects in the Physiological Changes in the Thoracic Viscera in Illness and Injury*, Doctor Young brought out in an able manner many interesting facts. Following a general discussion the meeting was adjourned.

There were thirty-four members and guests present.

Respectfully submitted,

CLAIR S. BAUMAN, *Secretary*,
Kennebec County Medical Association.

Penobscot

The regular monthly meeting of the Penobscot County Medical Association was held at the Bangor House, Bangor, Maine, on Tuesday, March 16, 1943.

The speaker of the evening was Bradford Cannon, M. D., Chief of Plastic Surgery Clinic, Massachusetts General Hospital, whose subject was *The Experience with Cocoanut Grove Casualties at the Massachusetts General Hospital.*

FORREST B. AMES, M. D.,
Secretary.

York

The York County Medical Society held its spring meeting on April 7, 1943, in Biddeford. Dinner was served at 1.00 P. M., at Hebert's Cafe, followed by the meeting at the Webber Hospital.

There were twenty members and guests present.

E. F. O'Gara, M. D., was granted a demit that he might transfer to Strafford County, N. H.

It was voted to hold the summer meeting at the Old Orchard Country Club.

An interesting talk was given by Lieut. Comdr. E. R. Mintz (M. C.), U. S. N., on *Renal Lithiasis.* Following the speaker, movies on *Syphilis* were shown by Edward M. Cook, M. D.

C. W. KINGHORN, M. D.,
Secretary.

New Members

Cumberland

Vincent Gould, M. D., Brunswick, Maine. (By transfer from the George Washington University Medical Society).

Hancock

Leon G. Hagopian, M. D., Southwest Harbor, Maine.

Royal G. Higgins, M. D., Bar Harbor, Maine.

Harry Kopfmann, M. D., Deer Isle, Maine.

Kennebec

Harry Elkins, M. D., Augusta, Maine.

Kurt A. Sommerfeld, M. D., Gardiner, Maine.

M. Eleanor Blish, M. D., State Department of Health, Augusta, Maine.

1st Lieut. John F. Reynolds, M. C., U. S. Army.

Waldo

Seth H. Read, M. D., Belfast.

Washington

Leslie W. Brownrigg, M. D., St. Stephen, New Brunswick.

Herbert S. Everett, M. D., St. Stephen, New Brunswick.

John Young, M. D., Jonesport, Maine.

Change of Address

Aroostook

Harold E. Small, M. D.
From: 151 Main Street, Fort Fairfield, Maine.
To: 31 Grove Street, Augusta, Maine.

*Members in Military Service**

Lincoln-Sagadahoc

Proctor, Thomas E., Boothbay Harbor

* These names of members in military service have been reported to the Journal office since publication of the preceding issue of the Journal, and supplement all lists published under this heading beginning with the September 1942 issue.

Program

MAINE MEDICAL ASSOCIATION

HOUSE OF DELEGATES

Sunday, June 20, 1943

Augusta House

Augusta, Maine

11.00 A. M.

First Meeting of the House of Delegates

Oscar F. Larson, M. D., Machias, Council Chairman, presiding, in absence of Stephen A. Cobb, M. D., President-elect, now in military service.

1.30 P. M.

Luncheon Meeting

Carl H. Stevens, M. D., Belfast, President, Maine Medical Association, presiding.

Speaker: A. William Reggio, Surgeon (R) U. S. P. H. S., Regional Medical Officer, First Civilian Defense Area.

Subject: Emergency Medical Service—Office of Civilian Defense. Film on Chemical Warfare.

Presentation of Fifty Year Medals.

4.30 P. M.

Second Meeting of the House of Delegates

Oscar F. Larson, M. D., presiding

County delegates are urged to attend this meeting in order that each County Society may have a voice in the many important issues now facing the medical profession. We are hoping for a 100% attendance, and hope that each delegate will make an effort to be present.

Members who are not delegates are also invited to attend this meeting, your opinions will be welcome, and given consideration by the House of Delegates.

Legislation of Interest to Physicians—Continued from page 96

priation of that department for general administration. The department may compensate hospitals at such rates as it may establish for hospital care of persons whose resources or the resources of whose responsible relatives are insufficient therefor. Bills itemizing the expenses of hospital care under the provisions hereof, when approved by the department of health and welfare, and audited by the state controller, shall be paid by the treasurer of state." Becomes law July 9, 1943.

11. Chapter 237—Repeals the requirement that "two reputable physicians" examining and certifying insanity before commitment be practitioners in the state "for a period of five years or more." Leaves it so they may be entirely new men in practice. Reason: many men are in the Service; it is necessary to use all that are available even though they have not been in practice five years or any particular period of time. Becomes law July 9, 1943.

The following were not passed:

1. Legislative Document 698—An Act Relating to State of Maine Cash Sickness Compensation. Adds a sickness insurance provision to the Unemployment Compensation law. Very liberal. Failed.

2. Legislative Document 377—State Department of Health and Welfare to inspect, supervise and issue licenses to "all private institutions and private boarding homes providing assistance, care or other direct services to children who are neglected, the blind and other dependent persons, etc." Extremely broad. Might be construed to include private hospitals but obviously not so intended. Failed. Ultimately.

3. Legislative Document 498—An Act Relating to Waiving of Pre-marital Blood Test. Added "Director of Health or a State District Health officer" as a quasi-judicial officer authorized to grant the waiver. Failed. Reason: it was thought that this judicial function now possessed by the Superior Court (and by Chapter 251 made to include Judges of Probate) had best not be exercised by other than judicial officials, i. e. judges.

There are other legislative proposals in which we are interested but they do not require comment, I think.

H. E. Locke.

Notices

State of Maine
Board of Registration of Medicine

Adam P. Leighton, M. D., Portland, Secretary.

List of physicians licensed to practice medicine and surgery in the State of Maine, March, 10, 1943.

Through Examination

Lawrence Crane, M. D., 237 Colville Road, Charlotte, N. C.

George H. Derry, Jr., M. D., 22 Arsenal Street, Portland, Maine.

James A. FitzGerald, M. D., 82 Perry Street, Brookline, Mass.

Donald B. Hawkins, M. D., Sedgwick, Maine.

John J. Reel, M. D., 1337 Second Street, Rensselaer, N. Y.

George L. Ross, M. D., St. Elizabeth's Hospital, Washington, D. C.

Stephen W. Semetauskis, M. D., Central Maine General Hospital, Lewiston, Maine.

Earl Kenneth Smith, Lieut. (jg), Medical Corps, U. S. N., U. S. Naval Hospital, Chelsea, Mass.

Through Reciprocity

Don D. Cornell, M. D., 113 Main Street, Gorham, Maine.

First Lieut. George B. O'Connell, Jr., M. C., St. Francis Hospital, Hartford, Conn.

Tumor Clinics

Bangor: *Eastern Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Magnus F. Ridlon, M. D.*

Lewiston: *Central Maine General Hospital*
Tuesday, 10.00 A. M.-12.00 M.
Director, *E. C. Higgins, M. D.*

St. Mary's General Hospital
Wednesday, 4.00 P. M.
Director, *R. A. Beliveau, M. D.*

Portland: *Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Mortimer Warren, M. D.*

Waterville: *Sisters Hospital*
1st & 3rd Thursdays, 10.00 A. M.
Director, *B. O. Goodrich, M. D.*

Thayer Hospital
2nd & 4th Thursdays, 10.00 A. M.
Director, *E. H. Risley, M. D.*

Hospital Notes

The Maine General Hospital has been a witness, within the past few years, to a rather phenomenal change in rate of maternity care. In 1942, 1,192 babies were born; in 1941, 918. To meet such an increase, the obstetrical department has been reconstructed, and meets in every respect the requirements of the modern department.

The present obstetrical department is divided into five parts: patients' units, prenatal and postnatal clinics, delivery rooms, formula room, nurseries. An isolation nursery cares for infectious cases.

The patients' units are on two floors. The private floor has seventeen private rooms, each with running water. The other floor comprises a thirty-two bed ward, made up of eight cubicle units of four beds each. To provide privacy for the patients, curtains, when pulled, completely screen each bed. Every other cubicle is equipped with running water. Three rooms provide facilities to care for eight semi-private patients.

The formula room, adjacent to the ward floor, is completely equipped for preparation of formulas. The average number of patients seen in the prenatal and postnatal clinics each month is 175. Newly constructed clinic rooms are now in use.

The delivery room suite consists of two labor rooms, two delivery rooms, equipped with resuscitation equipment for the newborn, and all other modern facilities for the care of obstetrical patients.

Such facilities, unless under proper guidance, may be of little actual benefit to the student. The Maine General Hospital has been fortunate to have an outstanding teaching staff, headed by Dr. Harold J. Everett and Dr. Theodore M. Stevens, and supervised by Ellen J. Hendrickson. The hospital can boast truthfully of the excellent training that its students receive under the tutelage of Miss Hendrickson, who is unexcelled in training, experience and ability by any in the country. This supervisor has ten graduate nurses who aid in the teaching of the students and in the care of patients in this department.

To each student who is receiving instruction in obstetrics, sixty hours of theoretical work accompany the three months' clinical experience obtained in the department. The sixty hours of theory are broken down into the following:

15 hours ..... doctors' lectures
30 hours ..... nursing classes
15 hours ..... practical demonstrations

This program is enriched by the use of movies, lectures by associated fields, such as Public Health, Social Service, and Ward Teaching Clinics. The clinical experience is arranged so that each student is allotted:
15-20 hours, clinics

4 weeks, care of ante-partum and post-partum patients
4 weeks, care of newborn and premature infants
1 week, preparation of formulas
3 weeks, labor and delivery rooms with a minimum of 12 sterile scrubs

The department is endeavoring in every possible way to offer the obstetrical patient the best and more recent methods of medical and nursing care, by using the latest approved techniques pertaining to obstetrics.

The Maine General Hospital has been approved by the Maine Board of Nurse Examiners for affiliation in obstetrics, and has for several years provided affiliation in obstetrics for one of Maine's schools of nursing. It is now offering the advantages for affiliation to other schools of nursing in Maine.

Sixth Annual Gerrish Library Lecture

The Sixth Annual Gerrish Library Lecture is to be held in the clinic room of the Central Maine General Hospital at 8.00 P. M., May 14, 1943. The speaker is to be Dean C. Sidney Burwell of the Harvard University Medical School, and his address is entitled: "Changing Viewpoints as to Disorders of Circulation."

Book Reviews

"Synopsis of Materia Medica, Toxicology, and Pharmacology"

For Graduates and Practitioners of Medicine

By: Forrest Ramon Davison, B. A., M. Sc., Ph. D., M. D., Medical Department, The Upjohn Co., Kalamazoo, Mich.; Formerly Assistant Professor of Pharmacology in the School of Medicine, University of Arkansas, Little Rock.

Second Edition.

With 45 Illustrations, Including 4 in color.

Published by The C. V. Mosby Company, St. Louis, 1942. Price, $5.75.

The thoroughly revised present edition has been brought up to conformity with the seventh edition of the National Formulary, the proposed twelfth edition of the United States Pharmacopoeia, and the British Pharmacopoeia (Fourth Addendum). The material on sulfonamide drugs has been considerably enlarged.

"Occupational Diseases"

Diagnosis, Medicolegal Aspects and Treatment

By: Rutherford T. Johnstone, A. B., M. D., Director of the Department of Occupational Diseases, Golden State Hospital, Los Angeles, California; Formerly Assistant Professor of Medicine, University of Pittsburgh School of Medicine.

Illustrated.

Published by W. B. Saunders Company, Philadelphia and London, 1941. Price, $7.50.

The medical and surgical service in industry is to give prompt emergency relief to the injured and to supply medical care and physical comfort to those who become ill while at work. However, in order that the physician may successfully fulfill all requirements of the practice of industrial medicine he must be well informed regarding the nature of accidents caused directly or indirectly by moving machinery; by poisonous gases, dyes, solvents, fuels, explosives, etc.; last, but not least, he must be well informed concerning the nature of human nature in health and disease, in contentment and the various states of worry, anxiety relative to work, security, family, as well as aberrations of efficiency due to conflicts arising from these factors coupled with states of fatigue resulting from continuously applied attention at physical or mental effort. The author tried hard and apparently has well succeeded in presenting to the medical profession an unusually large amount of illustrative material the diligent study of which should prove to be most beneficial to all those who must treat various kinds of industrial accidents and diseases as well as subsequent adjustment by compensation and to re-employment.

"A Manual of Pharmacology and Its Application to Therapeutics and Toxicology"

By: Torald Sollmann, M. D., Professor of Pharmacology and Materia Medica in the School of Medicine of Western Reserve University, Cleveland.

Sixth Edition, Entirely Reset.

Published by W. B. Saunders Company, Philadelphia and London, 1942. Price, $8.75.

The goal aimed at in this Manual of Pharmacology, namely, to furnish a comprehensive outline of current knowledge and conception of drug action with special reference to drug therapy and toxicology, has been reached in this new edition. Since much new material had to be added some of the older material had to be condensed, some had to be omitted, but all material mentioned in this great book's 1,165 packed pages can be readily studied further with the help of more than 100 pages of bibliographical reference information. A truly reliable guide to reliable knowledge on almost all matters of drug therapy and related spheres of scientific medical research.

Index to Advertisers

Borden Company, The	VI
Brewing Industry Foundation	XIII
Camel Cigarettes	IX
Coca-Cola	XII
Corn Products Refining Co.	VIII
Frye Company, Geo. C.	XII
Gay Private Hospital	XVII
Holland-Rantos Co., Inc.	X
Hospital Pharmacy, Inc.	XV
Hynson, Westcott & Dunning, Inc.	VIII
Jones' Private Sanitarium	XVII
Leighton's Hospital, Dr.	XVII
Lilly & Company, Eli	XIV
Maine Surgical Supply Co.	XVI
Marks Printing House	XV
Mead Johnson & Company	XIX
Medical Auditing Counsel	XV
Oakhurst Dairy	V
Parke, Davis & Company	III
Philip Morris & Co.	VII
Physicians Casualty Association	VIII
Prentiss Loring, Son & Co.	XV
S. M. A. Corporation	XVIII
State Street Hospital	XVII
Winthrop Chemical Co., Inc.	XI
Wyeth & Brother Inc., John	II
Zemmer Company, The	98

Patronize Your Advertisers

The Journal
of the
Maine Medical Association

Volume Thirty-four Portland, Maine, June, 1943 No. 6

*Notes on Medieval Guilds of Medicine**

By Howard T. Karsner, M. D.,** Cleveland, Ohio

From ancient times, men have banded themselves together into groups with various purposes, social, religious, educational, and protective. The organizations which are usually called guilds probably originated in Scandinavia and the northern part of the Continent. The exact time is not known, but it was certainly prior to the Christian era. The early guilds were social and religious. Three times a year the freemen gathered to feast and to drink to the gods and heroes. Much later, the toasts to Odin, Thor and their comrades were replaced by tributes to Christ and the Procession of the Saints. The custom of establishing guilds followed the migration of peoples. Thus in Germany, Holland, Belgium and in England, guilds were formed on the initiative of the people. They gradually evolved into merchants and crafts guilds. Central governments were not strong and sometimes practically non-existent. Consequently much of government resided in local communities and municipalities. As long as this was true, the guilds played an important and sometimes dominant part. In certain instances, officers of the guilds constituted the governmental council; in others members of the council were elected from among the freemen of the guilds. As monarchs became more powerful, the guilds, although established by the freemen, could continue only by royal charter.

The guilds of Italy, probably representative of southern Europe, were established by edict of the monarch rather than by the freemen. The scheme of organization was much the same as in the north and the participation in governmental affairs also on essentially the same basis.

Generally speaking, the merchant guilds were the most powerful in all communities. The wide contacts of their members, their great wealth and importance as citizens of a higher order, gave the merchant guilds rights and privileges not wholly shared by the crafts guilds. This distinction was not uniform and in certain places, such as Scotland, all the guilds were politically equal. The crafts guilds represented the various craftsmen and

* Address at Fifth Gerrish Library Anniversary, Central Maine General Hospital, Lewiston, Maine, July 24, 1942.

** From the Institute of Pathology, Western Reserve University, and the University Hospitals of Cleveland.

artisans. Included in this general group were the barbers, surgeons, physicians and apothecaries. These, however, were often ranked about midway between the merchants and the craftsmen. They shared in governmental and political affairs.

In these migrations and developments, different names were applied. In England and Scotland, there were at various times guilds, companies, livery companies and colleges. In Italy they were called collegia, corpora, scholae, companies and universities. These titles all signified essentially the same sort of body and the more high-sounding terms are not to be interpreted as having their modern meanings.

The guilds had customs and regulations, formalities and sometimes secrets, banners and insignia, seals and escutcheons, uniforms and other trappings. Insignia were used on shields, banners and seals and among the crafts were often used to guarantee the integrity of the product. If a mace were used, it was often surmounted by the insignia of the guild. Banners carried in processions might show the shield or some special device of the craft. Patron saints might be biblical characters or of local origin.

The guilds of especial interest to Medicine were those of the barbers, the surgeons, the apothecaries and the physicians. What in earlier times appeared to be allied crafts were often associated. Thus, peruke makers and midwives were included with the barber-surgeons. Painters, explorers and undertakers were associated with the doctors and apothecaries. Later, however, finer distinctions were drawn.

The story of only a few of the guilds can be included here. The barbers and surgeons of England have a history dating back to the fourteenth century. Prior to that time medicine and surgery were practiced by the clergy. The first clear record is in the time of Edward II, when an ordinance concerning the practice of surgery and objectionable advertising was passed. The earliest record of a barber being made a freeman of the guild of barbers is in 1312. In 1376, there is record of the annual appointment of two masters of the guild, and it is apparent that there were two classes of freemen, the barbers, who also did blood-letting and extraction of teeth, and the surgeons. There was also a guild of surgeons, but it numbered not more than 20 members. The two guilds were often in conflict, but the barbers were usually victorious because of their greater numbers and their intimate contacts with people of all classes. Various acts and laws were passed at different times, but they were not especially effective. In 1540, in the reign of Henry VIII, and largely due to his interest in both guilds, an act of parliament combined The Barbers Company and The Fellowship of Surgeons into the United Company of Barbers and of Surgeons. This union lasted more than two centuries and was dissolved in 1745. The barbers were then limited to the duties which prevail today. The surgeons organized their own company, but it was poorly managed and was dissolved in 1796. The Royal College of Surgeons was given a charter in 1800, and continues to exist as one of the licensing bodies of England. Until partly demolished by bombing in 1940, the magnificent building housed an excellent library and the famous Hunterian museum.

The Barbers Company was housed in a less impressive but nonetheless handsome building. Among its treasures is the painting by the younger Holbein, showing a meeting of Henry VIII and the Masters of the Company. Like most of the other livery companies of London, the Barbers Company has ceased to act as anything more than a social group. Five years ago, I asked the secretary if any barbers were members. After deep thought, he replied that there was one, a prominent barber of the fashionable West End of London!

The physicians of London were not organized until 1518, when Henry VIII granted a charter to The Royal College of Physicians of London. The term college represented an association or society for a common purpose, rather than an academic body. This guild was on the same legal plane as the Barber-Surgeons Company, including the right of licensing for practice.

The apothecaries were members of the Grocers Guild until 1606. In 1617, The So-

ciety of Apothecaries was incorporated with full rights of a guild. After many disputes as to authority, the Apothecaries were ultimately given the power of licensure for the practice of medicine, a privilege they still hold. Indeed, many practitioners of England have been licensed by The Society of Apothecaries.

In Scotland, the Chirurgeons and Barbours were granted a charter in 1505, which was ratified by James IV in 1506. James himself practiced surgery, such as treatment of wounds, extraction of teeth and couching for cataract. He sometimes collected fees and occasionally upon failure of his treatment he would recompense his patient. There was thus a bond of sympathy between James and the barber-surgeons and in addition to the usual privileges, the guild was given the sole right of manufacture and sale of aqua vitae, a franchise which must have been highly profitable. In 1722, the barbers were separated from the surgeons but were not allowed to incorporate as a guild. In 1697, the barber-surgeons built an anatomical theater and in 1705, a Chair of Anatomy was instituted which became a part of the University of Edinburgh. In 1778, the guild became the Royal College of Surgeons of Scotland and in that form still exists.

In the same year that the Barber-Surgeons Guild was formed, namely in 1505, a Faculty of Medicine was established in Aberdeen and in 1599, the Faculty of Physicians and Surgeons was founded in Glasgow. The physicians of Edinburgh made various attempts to form a society, but were not successful until 1670, when they were chartered as The Royal College of Physicians of Scotland.

It is evident that the guilds in Scotland were more intimately connected with the universities than was true in England. This association probably had much to do with the high level of medical teaching in Scotland, and through the influence of the Scottish tradition on the earlier medical schools in the United States was of importance in our development medically.

In Ireland, the Guild of Barbers and Surgeons dates back to 1446, but it made no distinction between the two crafts and had no teaching functions. The Royal College of Surgeons was established in 1784, but the Guild also continued to exist until 1840. A guild of physicians existed for a few years in the middle of the seventeenth century. In 1692, William and Mary granted a charter to the King's and Queen's College of Physicians. This organization took a serious interest in teaching and had control over licensing both physicians and apothecaries. In 1745, the apothecaries formed the Guild of St. Luke, which subsequently became the Apothecaries Hall of Ireland, empowered to conduct examinations and grant licenses.

The Guild of Doctors and Apothecaries of Florence was established at some time prior to 1197 and played an important part in the great days of that city. Enrolled in the guild were physicians, surgeons, barbers, midwives, painters, porcelain makers, silk and perfume agents, explorers and writers. The diversity of occupations in the guild was partly the result of the nature of the shops of the apothecaries. The doctors were permitted to enter into business partnerships with the apothecaries, but the latter were theoretically subordinate. Wealth meant much in Florence and the guild was one of the greater guilds, a position of more importance in local government than was true elsewhere with the possible exception of Edinburgh.

The apothecaries conducted their shops under supervision of the Guild, posted a bond with its treasurer and the shops were inspected each year by an appointee of the Guild. The shops exhibited and sold drugs and ointments, perfumes, gloves, sachets, buckles, various kinds of dishes, layettes for obstetrical cases, oiled leather for bandages, sponges, brushes, artists' pigments, books of all kinds, silks for clothing and haberdashery and many knickknacks. The apothecaries had the exclusive right to act as undertakers. They conducted the funeral ceremonies, provided the pall bearers and sold the various requisites such as coffins, torches, fireworks, candles, ornaments of all kinds, burial drinks and all other accessories. The apothecaries' shops were meeting places for men and women of Florence of high and low degree.

The Guild enrolled men of diversified in-

terest, some of whom were famous. Dante Alighieri was a member. Others included Matteo Palmieri, apothecary and poet, Leo Battista Alberti, physician, astronomer, architect and writer, and Antonio Benivieni, physician and man of letters. Printing, manufacture of books and engraving were recognized as appertaining to the guild, and Aldus Manutius was enrolled as member. Paolo Toscanelli renewed the Miletan theory of the spherical form of the earth. He corresponded with Queen Isabella and Columbus and although he died in 1482, the voyage of 1492 is said to have followed a route he selected. Amerigo Vespucci, agent of the Medici Company of Adventurers, provisioned two of Columbus's voyages. Before embarking on his own voyage of exploration, he visited Florence to obtain information and was matriculated in the Guild. The Guild held an important and significant place in the arts and sciences of Florence and thereby in the world.

This is but a brief survey of the guilds of the middle ages and renaissance, which have played a part in the development of the medicine of today, both in matters of organization and science. Their aspirations were in the direction of advancement of their profession and security for their members. Their insignia varied from the simple forms used by the earlier guilds of the low countries, to designs of great intricacy and noteworthy heraldic symbols, especially in the escutcheons of the British Guilds. They were sometimes objects of great beauty as in the shield of The Doctors and Apothecaries of Florence, executed by Lucca della Robbia. Certain of the shields show instruments of the art, such as fleams or lancets, trephines, bone forceps, spatulas, ointment boxes and urine glasses. Heraldic devices included figures such as the lion, the leopard, the rhinoceros, and other symbols of the profession. Especially in England, there were items such as the Tudor rose, signifying the royal favor.

Most of the medical guilds had patron saints. Of these Sts. Cosmas and Damian and St. Luke were especially popular. Cosmas and Damian lived in the third century, were the elder sons of Theodora of Aegea in Cilicia, were professed Christians and belonged to the group of Anargyri, taking no fees for their services. They were persecuted by Diocletian and executed in 303 A. D. Subsequently they were admitted to sainthood. They were also patron saints of the State of Florence and the Medici family.

Probably the most popular was St. Luke. His patronage covered physicians, surgeons, apothecaries and painters. The only evidence that he was a physician is found in the verse in Colossians, "Luke the beloved physician and Demas salute you." Examination of various writings on this problem leads to the view that although Luke was the best educated of the Disciples, he was probably neither physician nor painter. The Painters' Company of Florence was an offshoot of the Guild of Doctors and Apothecaries. In establishing this subsidiary guild, they took along with them the patron saint.

St. Kentigern, headmaster or lord, also known as St. Mungo (Munghu), dearest friend, was the patron of the Barber-Surgeons of Edinburgh and the guild supported his altar in the church of St. Giles. There is no evidence that he was anything more than a faith healer.

The Greeks were represented variously on the escutcheons. Apollo, the sun god and the god of health, Cheiron the centaur, Aesculapius and his sons, Machaon, the surgeon, and Podalirius, the physician, appear on the shields of many of the guilds, especially those in England and Scotland.

In modern times, guildry is represented by the trades unions. Guilds were not established by the early settlers who followed agricultural pursuits for the most part. Nevertheless, in Philadelphia there was the Carpenters' Company. The company had the high courage to permit the first Continental Congress to meet in Carpenters Hall, at a time when it might mean confiscation or worse. The Boston Academy of Arts and Sciences is a guild with livery and pageantry, but is rather an honorary society than a guild in the old sense. The College of Physicians in Philadelphia is a lineal descendant of the Royal College of Physicians of London, but although it has contributed significantly to

Continued on page 109

Editorials

House of Delegates, 1943

The Officers of the Maine Medical Association and the delegates representing the fifteen County Societies, which make up the State Association, will assemble at the Augusta House, Augusta, Maine, on Sunday, June 20th, for the first strictly business meeting in the history of the Association.

It was only after intense discussion and consideration of the various phases necessary to make up a successful scientific program by the members of the Council and Scientific Committee, that the Council voted to cancel the 91st annual session of the Association and to hold, in it's place, a one day business meeting.

Elsewhere in this issue is published the Order of Business for the two sessions of the House of Delegates; the routine business which the House must vote on annually in order that the work of the Association may be carried on in a manner representative of all the County Societies, and new business which at this time will undoubtedly come before this body. It has been the result of the deliberations of the members of the House of Delegates that has kept the Association together for 91 years and it will be the result of this year's assembly that will steer the course for the coming year.

Thirty-three delegates, plus substitute alternates, whose names are also published elsewhere in this issue, have been duly elected by the county societies to represent their respective groups at this meeting. The Officers of the Maine Medical Association are planning on a 100% attendance of these delegates, because a 100% attendance is necessary if each County Society is to be represented.

Members, who are not delegates, are also urged to attend the meetings of the House of Delegates. Any suggestions or criticism you have to offer will be welcome and given consideration by the members of the House.

A. William Reggio, Surgeon (R) U. S. P. H. S., Regional Medical Officer, First Civilian Defense Area, will speak on Emergency Medical Service — Office of Civilian Defense, at the luncheon meeting at 1.30 P. M. Civilian Medical Defense should be of interest to all members of the Association, particularly at this time when we are all becoming perhaps a little too optimistic. Doctor Reggio will also show a film on Chemical Warfare.

Presentation of the Association's fifty-year medals will also be a feature of the luncheon program.

Delegates and Members plan now to attend this war-time session of the House of Delegates of the Maine Medical Association in order that the purposes of the Association "to promote the science and art of medicine, the protection of public health, and the betterment of the medical profession," may go on in the future as in the past.

In This Issue

In this issue of the JOURNAL the annual reports summarizing the 1942-1943 work of the Association are published, in addition to the usual JOURNAL set-up.

Councilor reports, and reports from the majority of the Standing and Special Committees; proof that the members on the home front are making a gallant effort to carry on in time of war as in time of peace.

The reports of the Secretary-Treasurer; brief concise statements showing the status of the Association from a secretarial and financial viewpoint.

And the roster which lists all members in good standing as of May 31, 1943; active, military and honorary.

All of interest to every interested member of the Association, read them carefully for out of these reports must come the suggestions, and maybe criticism, which will keep the Association an active organization of which we may well be proud.

Maternal and Child Welfare

Feeding in the First Year

A previous article has urged that efforts be made to have mothers breast feed their babies. If this cannot be done, modified cow's milk or evaporated milk with added carbohydrate will serve. The various "ready to use" preparations will do nothing that cannot be done with some modification of milk, are expensive and encourage haphazard methods.

If cow's milk is used, it should be from a Holstein or Ayreshire herd. Guernsey milk will probably have to be partly skimmed, and Jersey milk is unsuitable for most infants. Cow's milk used for infant feeding should be boiled for three minutes even if it has been pasteurized, both for safety and for greater digestibility. The milk should then be cooled as rapidly as possible, the scum removed, and enough boiled water added to restore the original volume.

Evaporated milk has many advantages. It is easy to handle, and is a uniform and sterile product. It is especially useful when travelling, and for the many who nowadays change station frequently. It should be remembered that one ounce of evaporated milk is equivalent to a little over two ounces of whole milk. Babies on evaporated milk are apt to spit up a little more but this does no harm and they soon get over it.

It makes little difference what sugar is used. Karo is heavier than the others and is somewhat laxative. It has the disadvantage of accustoming the baby to sweet food. Dextri-maltose is slightly constipating, and lactose is between the two. An ounce or an ounce and a half of any of these is usually enough to add to the day's formula.

The modification of cow's milk has two purposes, to lessen the percentage of fat, and to render the protein more digestible. Cow's milk fat is harder to digest than that of human milk and so we give less of it. The protein is very different in composition from that of breast milk and much harder to digest because the curd is tough. The object of our treatment is to change this tough, rubbery curd to a soft, flaky one. Of the numerous methods, the following are easily applied: 1) Use evaporated milk. 2) Boil the milk three minutes. The constipating effect is negligible. 3) Use a cereal gruel as a diluent. One level tablespoonful of barley flour or cream of wheat cooked in a pint of water makes a good gruel. 4) Add sodium citrate to the mixture in the proportion of one grain to each ounce of milk. A solution containing twenty grains to the teaspoonful is a handy way to prescribe it. 5) Acidulate the milk with lactic acid, three cc. added drop by drop to each pint of milk which has been boiled and cooled. Karo is the sugar of choice for lactic acid milk.

The average newborn will take as his first formula a mixture of boiled milk and boiled water, equal parts, with added lactose or dextri-maltose, one level tablespoonful (Karo half as much) to each eight ounces of mixture. He may spit up a little at first. Do not be disturbed if he is otherwise well. He is probably just spilling over. For this, feed him in a semi-upright position and elevate the head of his bassinette. At the end of the meconium period there are apt to be some loose undigested stools, the transitional stools. These pass off in a few days and do not require a change of formula. Do not try too hard for an early weight gain. As the baby becomes more vigorous and requires more food, the strength of the mixture is gradually increased until at about three weeks the infant takes two-thirds milk and one-third water with added carbohydrate. He will need three ounces of this mixture per pound of body weight in twenty-four hours. This strength in increasing quantities is usually adequate for the first four months. The mixture is then gradually increased in strength until by the time he is eight months old, the infant has whole milk. If he seems to want more than a quart of milk, or more than forty ounces of mixture, he needs more solid food.

Strained orange juice should be started at about three weeks. Begin with a teaspoonful and increase to an ounce, later to two ounces. Occasionally orange juice disagrees. If this occurs, tomato juice may be given in at least double the quantity, or fifty milligrams of cevitamic acid may be given daily. Start cod liver oil during the second month, commencing with one-half teaspoonful twice daily, and increasing each dose to one teaspoonful. The concentrates are an improvement and can be given in doses of four or five drops once daily. Do not put cod liver oil in the milk, as it does not mix.

Cereal is started at four months. The various cooked, dried preparations are satisfactory. Pablum is said to be non-allergenic. Give a tablespoonful moistened with some of the formula and increase the amount as the baby becomes hungry. By five months he is usually ready to have a tablespoonful also at the six P.M. feed. There is no objection to a little sugar on the cereal if it is better taken that way. Shortly after starting the cereal, egg yolk is added to the diet, usually hard boiled and grated over the cereal. Some infants vomit it, in which case it should be omitted. Prune juice and pulp are next added. One or two tablespoonfuls are enough, as prunes are somewhat laxative. All these additions to the diet contain iron and help to combat the anemia which is likely to occur in the second half-year.

Strained vegetables are added to the two P.M. feed at six months. The canned, prepared ones are good. Start them one at a time so that if one disagrees or produces allergy it can be identified. Carrots, peas, and string beans are suitable. Spinach frequently causes upsets and is hardly worth bothering with. The first vegetable feeding is one teaspoonful, increasing to a tablespoonful, and later, more. When the infant has shown that he can digest vegetables, the various vegetable soups with liver or beef are very useful. Potato may be given at eight months, and a tablespoonful of ground beef, liver, lamb, or chicken at nine months. Dry toast is added when there are upper and lower teeth which meet. Apple sauce is often substituted for prunes, and ripe bananas, if obtainable, are a very good addition to the diet.

(To be continued.)

Your Committee on Maternal and Child Welfare.

Notes on Medieval Guilds of Medicine—Continued from page 106

American Medicine, never had the civic connections or authority of its progenitor.

Guilds still exist in Britain and on the Continent. They have largely become social organizations, often beautifully housed and in certain instances forwarding the interests of the arts and sciences. The successors of the medical guilds which have licensing powers, fulfill a useful function in that way and in honoring distinction in the profession. In the old City of London, the Aldermen are elected and the Lord Mayor chosen from among the members of the guilds, but the real authority in that congeries of cities which now constitute London lies with the London County Council.

We, of today, look back with admiration to those men of the guilds, who struggled to uphold their rights in the conflict between autocracy and freedom and who directed mighty efforts to the elevation of the arts and sciences. We are grateful for the traditions and practices which we have inherited.

The tuberculosis sanatorium cannot expect outside employers to hire ex-patients when it is not will to set the example. Experience justifies the employment of ex-tuberculous patients in hospitals, provided the selection is carefully made and the patient receives proper medical attention.—Max Pinner, M. D., Tuber. San. Conf. of Met., N. Y., 1941.

COUNTY SOCIETIES

Androscoggin
President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Thomas G. Harvey, M. D., Mars Hill
Secretary, Clyde I. Swett, M. D., Island Falls

Cumberland
President, J. Calvin Oram, M. D., So. Portland
Secretary, Eugene E. O'Donnell, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Charles C. Morrison, M. D., Bar Harbor
Secretary, Edward Thegen, M. D., Bucksport

Kennebec
President, Adolphe J. Gingras, M. D., Augusta
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Abbott J. Fuller, M. D., Pemaquid

Lincoln-Sagadahoc
President, Rufus E. Stetson, M. D., Damariscotta
Secretary, Albert S. Owen, M. D., Bath

Oxford
President, Lester Adams, M. D., Greenwood Mt.
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Ernest T. Young, M. D., Millinocket
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Maurice S. Philbrick, M. D., Skowhegan
Secretary, Maurice E. Lord, M. D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Arthur J. Stimpson, M. D., Kennebunk
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Lincoln-Sagadahoc

The annual meeting of the Lincoln-Sagadahoc County Medical Society was held at Hotel Sedgwick, Bath, Maine, May 13, 1943. President Edwin M. Fuller, Jr., M. D., in the chair.

Present: Drs. A. J. Fuller, Jr., Edwin F. Pratt, Robert Sommers, R. W. Mitchell, Virginia C. Hamilton, A. H. Morrell, A. S. Owen, R. F. Stetson, E. M. Fuller, Sr., W. E. Kershner, R. W. Belknap, N. L. Parsons, M. Eleanor Blish, Nathaniel Mills, J. W. Laughlin, and D. S. Day.

The applications of Charles N. Dennison, M. D., of Waldoboro; Miriam Doble, M. D., of Bath; Nathaniel Mills, M. D., of Bath; and Robert Sommers, M. D., of Richmond; were read and they were elected to membership in the society.

The following officers were elected for the ensuing year:

President, Rufus E. Stetson, M. D., Damariscotta.

Vice President, Virginia C. Hamilton, M. D., Bath.

Secretary-Treasurer, Albert S. Owen, M. D., Bath.

Delegate to the Maine Medical Association, James W. Laughlin, M. D., Newcastle.

Alternate, Warren E. Kershner, M. D., Bath.

Censors, Drs. E. F. Pratt, E. M. Fuller, Jr., and Robert W. Belknap.

Dr. Joseph D. McCloskey of the State Department of Health and the United States Public Health Service presented a very interesting professional paper.

W. E. Kershner, M. D.,
Secretary, Pro Tem.

Penobscot

The regular monthly meeting of the Penobscot County Medical Association was held at the Bangor House, Bangor, Maine, on Tuesday, April 20, 1943.

Dinner at 6.30 was followed by the Business Session and Scientific Meeting.

The speaker of the evening was Dwight O'Hara, M. D., Dean, Tufts College Medical School, whose subject was *The Decline of Air-Borne Infection.*

Forrest B. Ames, M. D.,
Secretary.

Washington

A meeting of the Washington County Medical Society was held at the Queen Hotel, St. Stephen, N. B., on Tuesday, May 18, 1943, at 6.40 P. M.

After a fine chicken dinner a short business meeting was held. This was followed by a lively and interesting discussion on *Obstetrics.*

Following the opening address by Walter N. Miner, M. D., President, all members gave their views on various phases of obstetrical practice.

It was felt that the meeting was a splendid example of what can be accomplished by group discussion. Everyone profited by the exchange of ideas.

There were ten present, nine members and one guest, E. O. Thomas, M. D., St. Stephen, N. B., who became a member of the Society.

Allen H. Knapp, M. D.,
Secretary.

New Members

Franklin

Herbert M. Zikel, M. D., Wilton, Maine.

Lincoln-Sagadahoc

Charles N. Dennison, M. D., Waldoboro, Maine.
Miriam Doble, M. D., Bath, Maine.
Nathaniel Mills, M. D., Bath, Maine.
Robert Sommers, M. D., Richmond, Maine.

Washington

E. O. Thomas, M. D., St. Stephen, N. B.

York

Charles Lengyel, M. D., Biddeford, Maine.

Members in Military Service*

Cumberland

Munro, Burton S.,	Berlin, N. H.

Kennebec

Michaud, Joseph H. B.,	Waterville
Pomerleau, Ovide F.,	Waterville

York

Cuneo, Kenneth J.,	Kennebunk
Holland, Edward W.,	Sanford
O'Sullivan, William B.,	Biddeford
Roussin, William T.,	Biddeford

* These names of members in military service have been reported to the Journal office since publication of the preceding issue of the Journal, and supplement all lists published under this heading beginning with the September 1942 issue.

NOTICE

Annual Meeting

Maine Medico-Legal Society

Sunday, June 20th, 1943 — 7.00 P. M., at the Augusta House

PROGRAM:

Dinner 7.00 P. M.

Business Meeting — Election of Officers.

Discussion of question "How far should the State go, in taking over from the Counties, in homicide cases?" Discussion opened by former Attorney General, Franz U. Burkett.

The Attorney General, several County Attorneys, and Pathologists and Medical Examiners will give their views.

Please pay dues ($1.00) at this meeting or send to, W. S. Stinchfield, M. D., Skowhegan, Maine, Treasurer.

G. L. PRATT,
Secretary.

Necrology

Harold Webb Garcelon,

1883-1943

Dr. Harold W. Garcelon died suddenly at his home in Auburn, April 17, 1943. He had been in active practice up to the morning when he died.

He was a son of the late Dr. A. M. Garcelon of Lewiston and a grandson of the late Dr. Alonzo Garcelon, a prominent pioneer surgeon in Maine, one time Governor of the State, and an outstanding figure in medical service during the Civil War.

Dr. Garcelon was a graduate of Bowdoin College in 1905, and of the Medical School of McGill University, Montreal, in 1908. He took a post-graduate year at the University of Edinburgh in Scotland where he received the triple qualifying degrees, and Fellowship of the Royal College of Surgeons and of the Royal College of Physicians.

On his return to the States in 1910, he served as intern at the Brooklyn, New York Hospital, and subsequently came back to Lewiston where he lived till he moved to Auburn.

He joined the staff of St. Mary's General Hospital in Lewiston in 1911, where he had been continuously active in the surgical services till the time of his death.

Dr. Garcelon served for many years on the local government pension boards. He was examining physician on the local Selective Service Board in Auburn from the time of its organization. He was a member of the Androscoggin County Medical Society, the Maine Medical Association, and the American Medical Association. He was also a member of the American College of Surgeons.

He was a member of the Masonic Bodies, including Kora Temple and The Order of the Eastern Star.

Dr. Garcelon served some ten years as member of the Superintending School Committee in Auburn. It was during his service on this committee that the new unit of the Edward Little High School was constructed, as was also the Walton School in New Auburn.

In 1912, he married Miss Gertrude Amger of Ohio, who survives him; as do also a son, Dr. Alonzo Garcelon, recently graduated from the Dental School of McGill University; a daughter, Miss Barbara Garcelon; three brothers, Alonzo H. Garcelon and Louis Garcelon, both of Boston, Massachusetts, and Dr. William T. Garcelon of Dark Harbor, Maine.

B. W. R.

In Memoriam

Members Deceased since May 31, 1942

Allen, Adelbert B.,	Richmond
Best, Herbert H.,	West Pembroke
Blake, James P.,	Harrison
Bunker, Luther G.,	Waterville
Currier, Everett B.,	Phillips
Freeman, Fred H.,	Pittsfield
Garcelon, Harold W.,	Auburn
Marsh, Ralph H.,	Guilford
Miller, George F.,	Belfast
Milliken, Herbert E.,	Surry
Mitchell, Alfred, Jr.,	Prouts Neck
Norell, Oscar,	Caribou
Owen, Herbert A.,	Bar Mills
Pelletier, Anthony D. J.,	Lewiston
Ross, Frank A.,	South Berwick
Ward, Parker M.,	Houlton
Williams, Adelbert F.,	Phippsburg
Wiseman, Robert J.,	Lewiston

Councilor Reports

Report of Councilor, First District

To the Officers and Members of the Maine Medical Association:

The Medical Societies of York and Cumberland Counties, due to conditions incident to the war, have not held the usual number of meetings. The York County Society has had three meetings and Cumberland County Society two meetings.

York County Medical Society has forty-two active members, two honorary members and twelve members in military service. During the year they have lost by death one member, Frank A. Ross, M. D.; one member, E. F. O'Gara, M. D., has been transferred from South Berwick to Dover, N. H.; and one new member has been admitted, Charles Lengyel, M. D., of Biddeford.

The first meeting was on October 14, 1942, at the Henrietta D. Goodall Memorial Hospital in Sanford, at which meeting moving pictures of gastric ulcer were shown and there was presentation of cases. The meeting was well attended and the members were much interested in the subject.

The Annual Meeting was held in January at the York Hospital in York Village, and the following officers were elected: President, Arthur J. Stimpson, M. D., Kennebunk; Vice President, Waldron L. Morse, M. D., Springvale; Secretary-Treasurer, C. W. Kinghorn, M. D., Kittery; Board of Censors: J. R. Larochelle, M. D., Biddeford; J. H. MacDonald, M. D., Kennebunk; Pliny A. Allen, M. D., York Harbor. Delegates: Edward M. Cook, M. D., York Harbor; James H. MacDonald, M. D., Kennebunk; C. W. Kinghorn, M. D., Kittery. Alternates: Gerald R. Smith, M. D., Ogunquit; and William H. Kelley, M. D., Sanford.

Lieut. Comdr., F. N. Gardner spoke on "Diabetes," after which there was considerable discussion by the members present.

The spring meeting was held in April at Biddeford. Sixteen members and four guests were present. The subject, "Kidney Stone," was presented by Lieut. Comdr. E. R. Mintz of Portsmouth, N. H.

During the year the average attendance has been thirty-eight per cent., somewhat lower than in previous years, but the interest in medicine and the organization has not waned.

The Cumberland County Medical Society at present has one hundred twenty-seven active members, forty-six members in the armed forces, and nine honorary members. Six new members, three of whom are by transfer, have been admitted, and three members have died during the year.

On January 13, 1943, a special meeting was held to discuss meningitis, especially of the meningococcic origin. The distribution, the diagnosis and treatment were so instructive and so practically presented that the meeting would have been enjoyed by all the physicians in the State. The attendance was large — there were many guests from other counties and medical men from the army and navy. The subject was fully discussed.

The Annual Meeting was held in April, and the following officers were elected: President, J. Calvin Oram, M. D., South Portland; Vice President, N. B. T. Barker, M. D., Yarmouth; Delegates: Clyde Richardson, M. D., Brunswick; Richard S. Hawkes, M. D., Portland; William Holt, M. D., Portland; Benjamin Zolov, M. D., Portland; Thomas A. Foster, M. D., Portland; DeForest Weeks, M. D., Portland; Frank A. Smith, M. D., Westbrook. Alternates: Ralf Martin, M. D., Portland; Oscar R. Johnson, M. D., Portland; Louis L Hills, M. D., Westbrook; and Joseph E. Porter, M. D., Portland.

Preceding the meeting, there was a clinic at the Maine General Hospital which was followed by a buffet lunch.

The meeting was held at the New Mercy Hospital. Maj. John L. Fromer spoke on "Allergy and Its Relation to General Practice."

Although there have been only two meetings during the year, these meetings were well attended and the interest and activity in the Society has not diminished.

E. Eugene Holt, Jr., M. D.,
Councilor, First District.

Report of Councilor, Second District

To the Officers and Members of the Maine Medical Association:

Following is my report as Councilor of the Second District which includes Androscoggin, Franklin and Oxford counties.

No official visit has been made to Androscoggin and Oxford counties. I have, however, on many occasions talked with members of each county and am convinced that each Association is well intact, that they are having their meetings as heretofore and conducting all necessary business, and are keeping a watchful eye to do all for the interest for the practice of medicine in their localities. The meetings, however, are not of any great proportion in attendance, not being due to lack of interest, but being controlled by the additional work that is thrust upon each member as the result of so many of the doctors being in the Armed Services.

C. C. Weymouth, M. D.,
Councilor, Second District.

Third District

Report for this District will be presented at the First Meeting of the House of Delegates on Sunday, June 20, 1943.

Report of Councilor, Fourth District

To the Officers and Members of the Maine Medical Association:

SOMERSET COUNTY

Somerset County held two meetings during the year. Both were business meetings, and there were no invited speakers.

No new members were taken into the Society.

There were no deaths among the members of the Society.

Six men are enlisted in the Army and Navy.

WALDO COUNTY

Waldo County held three meetings during the year. The Speakers at the meetings were:

I. Asa C. Adams, M. D., Orono, Maine.

II. Carl W. Ruhlin, M. D., Bangor, Maine.

III. Seth H. Read, M. D., Belfast, Maine; and R. L. Torrey, M. D., Searsport, Maine.

One new member was taken into the Society, Dr. Seth H. Read of Belfast, Maine.

There was one death, George F. Miller, M. D., Belfast, Maine.,

Three men are enlisted in the Army and Navy.

KENNEBEC COUNTY

Kennebec County held three meetings during the year. The Speakers at the meetings were:

I. Brig. Gen. J. G. Towne, M. C., Waterville, Maine.

II. Forrest C. Tyson, M. D., Augusta, Maine.

III. George E. Young, M. D., Skowhegan, Maine.

Four new members were taken into the Society: Harry Elkins, M. D., Augusta, Maine; Kurt A. Sommerfeld, M. D., Gardiner, Maine; M. Eleanor Blish, M. D., State Health Dept., Augusta, Maine; First Lieutenant John F. Reynolds, M. C., U. S. Army.

There were three deaths: Adelbert B. Allen, M. D., Richmond, Maine; Luther Bunker, M. D., Waterville, Maine; and Fred H. Freeman, M. D., Gardiner, Maine.

Twenty-seven men are enlisted in the Army and Navy.

Respectfully submitted,

John O. Piper, M. D.,
Councilor, Fourth District.

Report of Councilor, Fifth District

To the Officers and Members of the Maine Medical Association:

The Hancock County Medical Society has held a meeting every month since June, 1942, and also a Summer Clinic at the Bar Harbor Hospital. The attendance has been better even than last year which was a banner year in itself.

The meetings have been interesting and instructive, as they were usually addressed by out of state speakers, or two or three local men.

As was the case last year, the Dental Society held its meetings conjointedly with them.

The Washington County Medical Society held five meetings, one at Dennysville, three at Calais, and one at the Queen Hotel, St. Stephen, New Brunswick on May 18th.

The meetings were well attended with speakers from Maine, Massachusetts, and Canada.

Respectfully submitted,

Oscar F. Larson, M. D.,
Councilor, Fifth District.

Sixth District

To the Officers and Members of the Maine Medical Association:

Norman H. Nickerson, M. D., Councilor of the Sixth District, is in military service and has been unable to visit the societies in his district, namely Aroostook, Penobscot and Piscataquis.

Reports of meetings held by these societies, and published in the Journal, would indicate that they have been active throughout the year.

The Aroostook County Society has 31 active members, 6 in military service, and three honorary. Penobscot County has 75 active members, 16 in military service and one honorary, and Piscataquis County reports 9 active, 6 in military service and two honorary.

Frederick R. Carter, M. D.,
Secretary-Treasurer.

Committee Reports

Standing Committees

Committee on Medical Education and Hospitals

To the Officers and Members of the Maine Medical Association:

As Chairman of the Committee on Medical Education and Hospitals, I beg leave to state that there is very little more to report this year of interest other than was incorporated in my last year's report presented to the Association in June.

Hospital problems have increased in the past year, and the situation has become much more difficult than heretofore. All institutions are crowded to the doors and there is a most obvious diminution of the members of the medical, surgical and nursing staff.

The opening of the new Mercy Hospital in Portland has, at least, relieved temporarily, the situation to some extent, and it is hoped that conditions in Portland through the addition of these extra beds will be improved. We are indeed fortunate at this time to have this most excellent hospital in our midst.

Throughout the State, reports have been that all hospitals are not only undermanned but they have had added difficulties thrust upon them by the food and material shortages. Taking it all in all, I think that the Medical profession in Maine is to be congratulated because it has been able to carry on its hospital work in such a satisfactory manner.

The Maine General Hospital Unit, No. 67, left us last Fall and is now located in England. The sudden taking away of all these younger medical men and nurses, naturally, has made a most chaotic situation in Portland.

Other than the presentation of these generalities, this Committee has nothing more to offer.

Adam P. Leighton, M. D.,
Chairman.

Cancer Committee

To the Officers and Members of the Maine Medical Association:

Here follows my report as chairman of the Cancer Committee.

The committee as appointed last June consisted of:

Mortimer Warren, M. D., Portland (one year), Chairman.

Magnus Ridlon, M. D., Bangor (two years).

William Holt, M. D., Portland (three years).

Arthur McQuillan, M. D., Waterville (four years).

Julius Gottlieb, M. D., Lewiston (five years).

No meeting of the committee has been held this past year, due to the uncertainties of present conditions. There has been no critical need for such a meeting, since the general program is being continued under previously outlined procedures. This state of affairs, none the less, should not be offered as an excuse for forming a habit. Mutual discussion of problems and policies is essential.

A brief survey of the services in Maine for cancer patients was published in the current March number of The Journal of the Maine Medical Association. This was presented by Dr. Kobes, Dr. Ames, and Dr. Warren, who represent the Bureau of Health, The Women's Field Army, and the Cancer Committee, respectively. These are the three agencies which are directly concerned with carrying out the state program.

An all day session on cancer control for public health nurses took place in Portland on May 4, 1943. A similar institute was held in Bangor on May 5th. These successful meetings were planned and carried out by Dr. Kobes. Miss Franziska Glienke, consultant nurse for the Division of Cancer Control of the New York State Dept. of Health was guest speaker. From her wide experience she was able to illustrate for us in an interesting and instructive way the various aspects of the nurse's part in cancer control. Close coöperation between physicians in general, as well as those associated with clinics, and the nursing services are necessary for the full development of means to meet the responsibilities inherent in the conduct of tumor clinics.

Mortimer Warren, M. D.,
Chairman.

Public Relations Committee

To the Officers and Members of the Maine Medical Association:

The brightest page in our public relations for this year records our prompt response to the needs of the army and navy. Our uncoerced medical men have joined to one hundred per cent of our proportionate responsibility. Our young men, our strong men, have quietly, as becomes strong men, met the promise of their birthright and training.

For us who remain at home there are duties and responsibilities both heavy and grave. It is in these days of greater stress that the standards of our work are most likely to sag. War is used as an excuse for laxity in many fields. It must not invade ours. If we cannot meet all the demands, we can approach our work with careful scientific search for truth which alone lends direction to our professional life. The individual patient, once accepted, merits not short cuts or snap diagnoses, but adequate conscientious investigation and care. If we must fall let our casualties be in the quantity of work not in its quality. The individual practitioner has the quality and depth of our public relations in his keeping.

Consultation and other collaboration with quackery, giving it the aura of legitimate medical approval have taken us down to stygian levels hitherto unexplored by this great profession. It could not survive and thrive if some trained medical men and surgeons were not always ready to patch up its errors, relieve its anxieties, and cultivate it as a feeder of referred cases. To soothe and sustain this condition is bad but to be a partner to it is an all time low reached, in volume, this year.

It is noteworthy that this serious defect in our whole body developed in the period when Maine had no medical school. No fountain head for professional ethical culture. Coincidental perhaps, but many believe that a Maine Medical School could bring incentive and direction as well as guidance to our efforts.

After the war such doubtful measures as accelerated courses and certain other products of world disorder will sink into the oblivion deserved. A good medical school admitting only carefully examined and investigated applicants whose records and background can be known, using at least as much care in choosing them as is commonly exercised in picking a race horse or a milch cow, and teaching every man so chosen to practise medicine at the highest possible level of his understanding and training, would certainly be a step toward supplying the quality and inspiration which many believe is the missing ingredient in the professional life of this State.

That such a school is not beyond our depth is more than suggested by the record of the medical department of the University of Vermont where a Class A Medical School has been maintained in a city smaller than Bangor and with a total clinical facility less than one-third of that available in the Portland-Lewiston area. This school has supplied the Vermont villages with well trained physicians during that period when the villages of Maine were, to say the least, but poorly supplied with medical attention. It was during this period when we lost most in stature and in quality. Suggestive evidence of the need for a shrine in which to keep the ideas and ideals of medicine burning in the eyes of men, as well as in their minds.

R. Bliss, M. D.,
Chairman.

Legislative Committee

To the Officers and Members of the Maine Medical Association:

The Legislative Committee calls your attention to the May, 1943, issue of the Journal, page 94, for information regarding "Chapter 358, Public Laws 1943, Requiring Venereal Disease Patients to take Treatment, and Physicians to report the cases," page 95, for copy of this law which became effective on April 9, 1943, and page 96, for a complete report on "Legislation of Interest to Physicians Offered at 1943 Maine Legislature and Action Thereon," as submitted by Herbert E. Locke, Attorney.

Frederick R. Carter, M. D.,
Chairman.

Special Committees

Committee on Graduate Education

To the Officers and Members of the Maine Medical Association:

I hereby submit my report as Chairman of the Committee on Graduate Education for the year 1942-43.

At the Annual Meeting of the Association last year a plan of Home Study Courses was suggested as a means of providing Graduate Education during the War Emergency. It was realized that few, if any, of the Fellowships previously sponsored by the Bingham and Commonwealth Funds, would be available for the coming year. For the most part these had been restricted to men under 40 years of age, and most physicians in this group would be in the military forces. In addition, the Funds were necessarily curtailing their expenditures, and few of the physicians left in practice would be able to get time for such courses. In 1942, only seven men took courses through the Bingham Fund, and four through the Commonwealth Fund. The Home Study Courses were brought forward as a means of meeting this deficiency.

Previously your committee has endeavored to stimulate the presentation of Scientific programs at County Meetings, and to encourage teaching programs for hospital staff meetings. It was hoped that these two media for Graduate Education would be continued.

Home Study Courses were planned in Surgery, Medicine, Pediatrics and Obstetrics. An endeavor was made to enlist a number of leaders in these several fields who, acting as Instructors, would prepare lists of questions based upon articles in the literature. A group of questions, together with the references, were to be sent monthly to each applicant for the courses. These applicants were to write discussions based upon the given references, which then would be sent to the men, acting as Instructors, to be criticized, after which the papers would be returned to the applicants. The purpose of this was, of course, to stimulate organized reading.

Considerable difficulty was found in enlisting men to act as Instructors. Finally the work in Surgery and Medicine was organized and a beginning made with Pediatrics and Obstetrics.

Twenty-four physicians applied for the courses. Only five completed them. Of the subcommittees, acting as Instructors, Surgery came through quite satisfactory, almost wholly due to the efforts of Drs. E. H. Risley and F. H. Jackson, while Dr. L. H. Smith did good work with Medicine.

We must, however, consider that the experiment in Home Study Courses was a failure. That this is so is due to the complete lack of coöperation and interest, with few exceptions, of the men serving on the various subcommittees. It is interesting to note that quite a number of requests for these courses were received during the year from all over the Country, even from as far away as Arizona. It is regretted that more interest could not have been shown in our own State, especially among men who should have been interested in furthering Medical Education.

In conclusion, we can only say that the work of the committee on Graduate Education for the year has been practically devoid of results. It behooves Medicine to look to itself lest the present "blackout" of scientific interest results in a serious and permanent setback to the previously advancing Standards of Practice.

Frederick T. Hill, M. D.,
Chairman.

Committee on Maternal and Child Welfare

To the Officers and Members of the Maine Medical Association:

The committee met as soon as practicable after its appointment. The members agreed that its function was to stimulate the interest of the family physician in prenatal care, the care of the newborn, and the supervision of the mental and physical development of children.

It was decided that the most practicable method of presenting our ideas to the profession was to write a series of articles. Accordingly, one has appeared each month, beginning with the September, 1942, issue of The Journal of the Maine Medical Association.

The committee in one article urged county societies to devote a meeting to prenatal care, and offered to provide speakers or material for talks on that subject or on the care of infants. This suggestion met with no response.

For obvious reasons no further meetings were held, but members were in communication by correspondence. We realize that we have but started on an important work, and hope that the society will continue efforts to improve prenatal and neonatal care in the state.

The Committee on Maternal and Child Welfare.
Albert W. Fellows, M. D.,
Chairman.

Committee on Industrial Health

To the Officers and Members of the Maine Medical Association:

Your committee arranged to take over and conduct one morning's session of the Safety Conference, sponsored by the State Department of Labor and Industry in Portland in September, 1942. The committee arranged and presented seven papers on pertinent, industrial health topics.

We have again been invited to take part in this year's program. Your committee has been asked and has agreed to present a paper on Industrial Nursing before the New England section of the American Nursing Association at Poland Spring on June 9, 1943.

The committee has, through the county secretaries and personal letters, endeavored to list surgeons interested in and available for Industrial Health work in this state. We have also listed the various plants supporting such services.

Joseph B. Drummond, M. D.,
Chairman.

Committee to Investigate Collection Agencies

To the Officers and Members of the Maine Medical Association:

As far as a report as the Committee of One to Investigate Collection Agencies is concerned, I have nothing to add to my report of last year. My observations and remarks of a year ago still hold good, and if anyone desires the services of an efficient, honest and reliable collection agency, I shall be glad to answer any inquiries for information.

Adam P. Leighton, M. D.,
Committee.

Report of the Secretary

To the Members of the Maine Medical Association:

As your Secretary I am pleased to submit the following report.

There are 748 members in good standing in the Association; 541 active, 176 in military service, and 31 honorary. Twenty-eight members have been added to the roster during the past year, and six have been re-instated to membership. We have lost eighteen members by death, six have moved out of the State, and one has retired and resigned from membership.

100% payment of dues has been received from all county societies. This not only establishes a record for the Association, but is evidence of the whole-hearted coöperation of our county Secretaries and members.

Because of the war emergency the Council of the Maine Medical Association voted to cancel the Fall Clinical Session and the 91st annual session. It was, however, voted to hold a one-day business meeting of the Officers of the Maine Medical Association, and delegates representing the County Societies, at Augusta, on Sunday, June 20, 1943. The Order of Business for this meeting will be found elsewhere in this issue. A luncheon meeting at which A. William Reggio, Surgeon (R) U. S. P. H. S. Regional Medical Officer, First Civilian Defense Area, will speak, will make a comfortable break between the two sessions of the House of Delegates scheduled for that day. The Association's Fifty-Year Medals will be presented at the luncheon to the following members who by completing half a century in the practice of medicine well deserve this honor we are privileged to bestow upon them: Royal G. Higgins, M. D., Bar Harbor; Langdon T. Snipe, M. D., Bath, Past President of the Maine Medical Association; and Oliver W. Turner, M. D., Augusta. It is with regret that I report the recent death of Everett B. Currier, M. D., who would also have received a medal at this meeting, and whose medal will be forwarded to Mrs. Currier.

I wish to express my appreciation to the County Secretaries, Councilors, and Officers of the Association, for their coöperation during the year now past, a year which has tried the souls of all men. Also to those members of the Association whose duty in this time of war is on the home front, and to those members now in Military Service, who by their numbers alone have once again proved that Maine physicians are ready and willing to answer their Country's call when the need demands.

Respectfully submitted,

Frederick R. Carter, M. D.,
Secretary.

May 31, 1943.

Report of the Treasurer

To the Members of the Maine Medical Association:

As your Treasurer I am pleased to submit the following report.

The books of the Association and Journal were closed and audited as of May 31, 1943, by Jordan and Jordan, Accountants and Auditors, Portland, Maine, who have "found the same complete and correct in all details of record." Following is a portion of the Auditor's Report. The complete report, copy of which has been sent to each member of the Financial Advisory Committee, is on file in the Portand Office where it is available to any member of the Association.

You will note that our expenses for the 1942-1943 period exceeded our income by $936.29. This is caused by a loss in income from annual dues of $1,408.00, for the 176 members now in military service, whose dues are exempt in accordance with a vote of the House of Delegates in session at York Harbor, Maine, June, 1941. The deficit was covered by a withdrawal of $1,000.00 from the Association's savings. I feel that the prudence and forethought of those who have gone before in making these monies available should be commended.

The Journal fared well during this period, however, and I am indeed pleased to report that the advertising receipts exceeded the printing cost by $284.16.

I hope every member will read this report carefully and familiarize himself with the financial status of the Association.

Respectfully submitted,

Frederick R. Carter, M. D.,
Treasurer.

Balance Sheet, May 31, 1943

ASSETS

Cash in Banks	$14,321.62
Accounts Receivable — Sundry	30.96
Dues Receivable	128.00
Advertising Receivable	314.01
Securities	6,605.00
Furnishings and Equipment	1,092.59
Impounded Cash	1,301.79
	$23,793.97
Trust Fund Investments	2,309.31
Total Assets	$26,103.28

LIABILITIES, CAPITAL AND TRUST FUNDS

Liabilities	$ 0.00
Capital Account	23,793.97
Trust Funds	2,309.31
Total Liabilities, Capital and Trust Funds	$26,103.28

Statement of Revenue and Expense,

One Year Ended May 31, 1943

REVENUE

Dues	$ 4,336.00
Income from Securities	364.17
Interest Received	199.98
Exhibit Space — 1942 Convention	651.00
C. M. A. B. Advertising	2,407.28
Local Advertising	1,105.73
Subscriptions and Sales of Journals	28.60
Total Revenue	$ 9,092.76

EXPENSES

Salaries:—		
Dr. Carter, Secretary, Treasurer and Editor	$2,200.00	
Mrs. Kennard, Assistant Secretary	1,500.00	
Travel Expenses:—		
Secretaries	2.00	
Councilors	125.15	
Office Expenses:—		
Office Assistants	23.00	
Supplies and Stationery	225.40	
Postage and Mailing Expense	200.46	
Rent	300.00	
Telephone	120.71	
Lights	12.00	
Auditing	58.50	
Miscellaneous	73.09	
Committees, Graduate Education and Legislature	19.50	
Delegates, N. E. Medical Societies	77.68	
A. M. A. Meeting	81.00	
Medical Advisory Committee	500.00	
Annual Meeting	1,019.66	
Printing	3,396.17	
Plates	94.73	
Total Expenses		10,029.05
Expense in Excess of Revenue — One Year		$936.29

Statement of Cash Receipts and Disbursements,

One Year Ended May 31, 1943

Cash in Banks, June 1, 1942		$14,921.73
RECEIPTS		
Received from Dues	$4,312.00	
Income from Investments	564.15	
Exhibit Space Rentals	430.50	
Liquidating Dividend — Fidelity Trust Co.	202.26	
Subscriptions and Sale of Journals	28.60	
Advertising	3,521.19	
Mortbon Corp. of N. Y. "B" 5's, 1946, called at 100	400.00	
		9,458.70
		$24,380.43

DISBURSEMENTS

Salaries	$3,700.00	
Traveling Expenses	127.15	
Office Expenses	1,013.16	
Committees and A. M. A. Meeting	178.18	
Annual Meeting — 1942	1,018.46	
Medical and Advisory Committee	500.00	
Printing and Plates	3,505.76	
Gerrish Memorial Library — Postage	16.10	
		10,058.81
Cash in Banks — May 31, 1943		$14,321.62
Canal National Bank — Checking Account	$2,884.50	
Canal National Bank — Savings Account	1,606.33	
Maine Savings Bank	4,708.42	
Portland Savings Bank	4,669.71	
First National Granite Bank	452.66	
		$14,321.62

Order of Business

Maine Medical Association House of Delegates Meeting

Sunday, June 20, 1943

Augusta House

Augusta, Maine

First Meeting

11.00 A. M.

Chairman—Oscar F. Larson, M. D., Council Chairman

Call to Order by Chairman.

Roll Call by Secretary (ten delegates a quorum).

Appoint Reference Committee (three delegates).

Appoint Nominating Committee (This Committee to draw up a slate of Standing Committee members for 1943-44, and report their deliberations to the Second Meeting of the House at 4.30 P. M.).

Report of Council for 1942-43 (to be made by the Chairman of the Council).

Presentation of 1943-44 Budget as Recommended by the Council (to be presented by the Chairman of the Council).

Report of Thomas A. Foster, M. D., Delegate to the 1943 Meeting of the House of Delegates of the American Medical Association.

Reports of Standing Committees (not submitted for publication in the June issue of the Journal).

Reports of Special Committees (not submitted for publication in the June issue of the Journal).

New Business.

Luncheon Meeting

1.30 P. M.

Presiding: Carl H. Stevens, M. D., President, Maine Medical Association.

Speaker: A. William Reggio, Surgeon (R) U. S. P. H. S., Regional Medical Officer, First Civilian Defense Area.

Subject: Emergency Medical Service—Office of Civilian Defense. Film on Chemical Warfare.

Presentation of Fifty-Year Medals.

Second Meeting

4.30 P. M.

Chairman—Oscar F. Larson, M. D., Council Chairman

Call to Order by Chairman.

Roll Call by Secretary (ten delegates a quorum).

Report of Nominating Committee by Committee Chairman (Secretary to cast ballot of the House for slate as read).

Report of Reference Committee by Committee Chairman.

Election of Councilors from Fifth and Sixth Districts:

(Fifth District — Hancock and Washington Counties.)

(Sixth District — Aroostook, Penobscot and Piscataquis Counties.)

Unfinished Business.

New Business:

Appointment of a Presiding Officer for 1943-44. Stephen A. Cobb, M. D., President-elect now in Military Service.

Election of President-elect.

Official Delegates from the County Medical Societies

First District

Cumberland County

Delegates: (Two years)

C. Earle Richardson, M. D., Brunswick.
Richard S. Hawkes, M. D., Portland.
William Holt, M. D., Portland.
Benjamin Zolov, M. D., Portland.

(One year)

Thomas A. Foster, M. D., Portland.
DeForest Weeks, M. D., Portland.
Frank A. Smith, M. D., Westbrook.

Alternates: (Two years)

Ralf S. Martin, M. D., Portland.
Oscar R. Johnson, M. D., Portland.

(One year)

Louis L. Hills, M. D., Westbrook.
Joseph E. Porter, M. D., Portland.

York County

Delegates:

Edward M. Cook, M. D., York Harbor.
James H. MacDonald, M. D., Kennebunk.
Charles W. Kinghorn, M. D., Kittery.

Alternates:

Gerald R. Smith, M. D., Ogunquit.
William H. Kelly, M. D., Sanford.

Second District

Androscoggin County

Delegates:

Ralph A. Goodwin, M. D., Auburn.
Horace L. Gauvreau, M. D., Lewiston.
William H. Chaffers, M. D., Lewiston.

Franklin County

Delegate:

George L. Pratt, M. D., Farmington.

Alternate:

Cecil F. Thompson, M. D., Phillips.

Oxford County

Delegates:

Dexter E. Elsemore, M. D., Dixfield.
Harold W. Stanwood, M. D., Rumford.

Alternates:

Walter G. Dixon, M. D., Norway.
Garfield G. Defoe, M. D., Dixfield.

Third District

Knox County

Delegates:

C. Harold Jameson, M. D., Rockland.
James Carswell, M. D., Camden.

Alternates:

Herman J. Weisman, M. D., Rockland.
Abbott J. Fuller, M. D., Pemaquid.

Lincoln-Sagadahoc Counties

Delegate:

James W. Laughlin, M. D., Newcastle.

Alternate:

Warren E. Kershner, M. D., Bath.

Fourth District

Kennebec County

Delegates:

Blynn O. Goodrich, M. D., Waterville.
Ivan E. McLaughlin, M. D., Gardiner.
Frank B. Bull, M. D., Gardiner.
L. Armand Guite, M. D., Waterville.

Alternate:

Chalmers G. Farrell, M. D., Gardiner.

Somerset County

Delegate:

Walter S. Stinchfield, M. D., Skowhegan.

Alternate:

Henry E. Marston, M. D., No. Anson.

Waldo County

Delegate:

Foster C. Small, M. D., Belfast.

Alternate:

Eugene L. Stevens, M. D., Belfast.

Fifth District

Hancock County

Delegate:

Edward Thegen, M. D., Bucksport.

Alternate:

R. V. N. Bliss, M. D., Bluehill.

Washington County

Delegate:

Willard H. Bunker, M. D., Calais.

Alternate:

Dacosta F. Bennett, M. D., Lubec.

Sixth District

Aroostook County

Delegates:

Thomas G. Harvey, M. D., Mars Hill.
Eugene H. Doble, M. D., Presque Isle.

Alternates:

Clyde I. Swett, M. D., Island Falls.
Herrick C. Kimball, M. D., Ft. Fairfield.

Penobscot County

Delegates:

Ernest T. Young, M. D., Millinocket.
Frank D. Weymouth, M. D., Brewer.
Samuel S. Silsby, M. D., Bangor.
Leroy H. Smith, M. D., Winterport.

Alternates:

Martin C. Maddan, M. D., Old Town.
Carl E. Blaisdell, M. D., Bangor.
Forrest B. Ames, M. D., Bangor.
Hugh G. McKay, M. D., Old Town.

Piscataquis County

Delegate:

Fred J. Pritham, M. D., Greenville Jct.

Alternate:

Ralph C. Stuart, M. D., Guilford.

OFFICIAL ROSTER

OF THE

MAINE MEDICAL ASSOCIATION

MEMBERS

MEMBERS IN MILITARY SERVICE

HONORARY MEMBERS

MAY 31, 1943

Members in Military Service

ANDROSCOGGIN

BEEAKER, VINCENT,	Lewiston
BELIVEAU, BERTRAND A.,	Lewiston
BOUSQUET, JEAN,	Lewiston
BROOKS, GLIDDEN L.,	Lewiston
CHEVALIER, PAUL R.,	Lewiston
CLAPPERTON, GILBERT,	Lewiston
COX, WILLIAM V.,	Auburn
FROST, ROBERT A.,	Auburn
GREENE, MERRILL S. F.,	Lewiston
HARKINS, MICHAEL J.,	Lewiston
MANDELSTAM, ABE W.,	Lewiston
STEELE, CHARLES W.,	Lewiston
TIBBETTS, OTIS BENSON,	Auburn
TOUSIGNANT, CAMILLE,	Lewiston
WEBBER, WEDGWOOD P.,	Lewiston
VILES, WALLACE E.,	Turner

AROOSTOOK

DONAHUE, GERALD H.,	Presque Isle
EBBETT, GEORGE H.,	Houlton
GAGNON, BERNARD,	Houlton
GORMLEY, EUGENE G.,	Houlton
LABBE, ONIL B.,	Van Buren
TOUSSAINT, LEONID G.,	Fort Kent

CUMBERLAND

BLAISDELL, ELTON R.,	Portland
BRANSON, SIDNEY R.,	So. Windham
CASEY, WILLIAM L.,	Portland
CHRISTENSEN, HARRY E.,	Portland
CLANCEY, DANIEL J.,	Portland
DANIELS, DONALD H.,	Portland
DAVIS, PAUL V.,	Bridgton
DOUPHINETT, OTIS J.,	Portland
DRAKE, EUGENE H.,	Portland
DUNHAM, CARL E.,	Portland
FAGONE, FRANCIS A.,	Portland
FINKS, HENRY B.,	Portland
FOGG, C. EUGENE,	Portland
GETCHELL, RALPH A.,	Portland
GRECO, EDWARD A.,	Portland
HAM, JOSEPH G.,	Portland
HANLON, FRANCIS W.,	Portland
HEIFETZ, RALPH,	Portland
HEBB, HENRY S.,	Bridgton
HOLT, C. LAWRENCE,	Portland
HYNES, EDWARD A.,	So. Portland
JOHNSON, ALBERT C.,	Portland
JOHNSON, GORDON N.,	Portland
LAUGHLIN, K. ALEXANDER,	Portland

LEIGHTON, WILBUR F.,	Portland
LOMBARD, REGINALD T.,	So. Portland
LOTHROP, EATON S.,	Portland
LOVE, ROBERT B.,	Gorham
LOVELACE, DANIEL D., JR.,	Gorham
MARSTON, PAUL C.,	Kezar Falls
McCRUM, PHILIP H.,	Portland
McLEAN, E. ALLAN,	Portland
McMANAMY, EUGENE P.,	Portland
MOORE, ROLAND B.,	Portland
MORRISON, ALVIN A.,	Portland
MUNRO, BURTON S.,	Berlin, N. H.
OTTUM, ALVIN E.,	Portland
PHILLIPS, ROBERT T.,	Portland
POORE, GEORGE C.,	Portland
SCHWARTZ, CAROL,	Portland
SIMECEK, VICTOR H.,	Brunswick
SMITH, KENNETH E.,	Portland
SPENCER, JACK,	Portland
TABACHNICK, HENRY M.,	Portland
THOMPSON, MILTON S.,	Portland
WILLIAMS, RALPH E.,	Freeport

FRANKLIN

BRINKMAN, HARRY,	Wilton
COLLEY, MAYNARD B.,	Wilton
LaTOURETTE, KENNETH A.,	Farmington
REED, JAMES W.,	Farmington
SCHMIDT, LORRIMER M.,	Strong
SPRINGER, FRANK L.,	Farmington

HANCOCK

COFFIN, ERNEST L.,	Northeast Harbor
COFFIN, RAYMOND B.,	Southwest Harbor
COFFIN, SILAS A.,	Bar Harbor
LARRABEE, CHARLES F.,	Washburn
SUMNER, CHARLES M.,	West Sullivan
TORREY, MARCUS A.,	Ellsworth
TROWBRIDGE, MASON,	Ellsworth
WEYMOUTH, RAYMOND E.,	Bar Harbor

KENNEBEC

ALMOND, HENRY,	Gardiner
BOURASSA, HARVEY J.,	Waterville
BULL, FRANK B.,	Gardiner
COOK, AARON,	Waterville
CYR, GERALD A.,	Waterville
FAY, THOMAS F.,	Augusta
FISHER, SAMSON,	Oakland
GINGRAS, NAPOLEON J.,	Augusta
HARDY, THEODORE E., JR.,	Waterville
HURD, ALLAN C.,	Gardiner
IRGENS, EDWIN R.,	Waterville
LAMBERT, GREENLEAF H.,	Winthrop
LATHBURY, VINCENT T., JR.,	Augusta
McLAUGHLIN, IVAN E.,	Gardiner
McWETHY, WILSON H.,	Augusta
METZGAR, JOHN G.,	Augusta
MICHAUD, JOSEPH H. C.,	Waterville
MURPHY, NORMAN B.,	Augusta
POMERLEAU, OVIDE F.,	Waterville
POMERLEAU, RODOLPHE J. F.,	Waterville
PRATT, T. DENNIE,	Waterville
PROVOST, PIERRE E.,	Augusta
REYNOLDS, JOHN F.,	Augusta
SHELTON, M. TIECHE,	Augusta
TOWNE, CHARLES E.,	Waterville
TOWNE, JOHN G.,	Waterville
TRASK, BURTON W., JR.,	Rumford

KNOX

APOLLONIO, HOWARD L.,	Camden
DENNISON, FREDERICK C.,	Thomaston
EARLE, RALPH P.,	Vinalhaven
JONES, PAUL A.,	Union
KAZUTOW, JOHN,	Bangor
TOUNGE, HARRY G., JR.,	Camden
WASGATT, WESLEY N.,	Rockland

LINCOLN-SAGADAHOC

LENFEST, STANLEY R.,	Waldoboro
PROCTOR, THOMAS E.,	Boothbay Harbor
SMITH, JACOB,	Bath
STOTT, ARDENNE A.,	Bath
WINCHENBACH, FRANCIS A.,	Bath

OXFORD

BEAN, JOHNSON L.,	Norway
COHEN, LEON,	Fryeburg
CORLISS, LELAND M.,	West Paris
COURVILLE, ALBERT L.,	Rumford
DANIELS, S. DAVID,	Hebron
DIXON, WALTER G.,	Norway
EASTMAN, CHARLES W.,	Livermore Falls
HOWARD, HENRY M.,	Rumford
JACKSON, NORMAN M.,	Andover
VILLA, JOSEPH A.,	So. Paris
WILSON, HARRY M.,	Bethel

PENOBSCOT

BUTLER, HARRY,	Bangor
CLOUGH, HERBERT T., JR.,	Bangor
COMEAU, WILFRED J.,	Bangor
CUTLER, LAWRENCE M.,	Bangor
EMERY, CLARENCE, JR.,	Bangor
FEELEY, J. ROBERT,	Bangor
GREGORY, I. FRANCIS,	Bangor
HINMAN, HAVILAH E.,	Orono
HOULIHAN, JOHN S.,	Bangor
MIRAGLIUOLO, LEONARD G.,	Bangor
OSLER, JAY K.,	Bangor
PRESSEY, HAROLD E.,	Bangor
SHAPERO, BENJAMIN L.,	Bangor
SMITH, JOHN E.,	Bangor
TODD, ALBERT C.,	So. Brewer
WITTE, MAX E., JR.,	Bangor

PISCATAQUIS

CURTIS, JOHN B.,	Milo
MARSH, BURTON S.,	Greenville Jct.
HOWARD, GEORGE C.,	Guilford
NICKERSON, NORMAN H.,	Greenville
THOMAS, RUTH B.,	Dover-Foxcroft
THOMAS, WILLIAM B. S.,	Dover-Foxcroft

SOMERSET

BALL, FRANKLIN P.,	Bingham
BRANN, HENRY A.,	Madison
BERNARD, ALBERT J.,	Skowhegan
LANEY, RICHARD P.,	Skowhegan
STINCHFIELD, ALLAN J.,	Skowhegan
SULLIVAN, GEORGE E.,	Bingham

WALDO

CASWELL, JOHN A.,	Belfast
JONES, RICHARD P.,	Belfast
NESBITT, LESTER R.,	Bucksport

WASHINGTON

COBB, NORMAN E.,	Calais
METCALF, JOHN,	Lubec

YORK

COBB, STEPHEN A.,	Sanford
CUNEO, KENNETH J.,	Kennebunk
DOWNING, JERE R.,	Kennebunk
GOULD, GEORGE I.,	Auburn
HILL, PAUL S., JR.,	Saco
HOLLAND, EDWARD W.,	Sanford
KENDALL, CLARENCE F.,	Flushing, N. Y.
MURPHY, JOHN J.,	Wells Beach
MYER, JOHN C.,	No. Berwick
O'SULLIVAN, WILLIAM B.,	Biddeford
RICHARDS, CARL E.,	Alfred
ROUSSIN, WILLIAM T.,	Biddeford
TOWER, ELMER M.,	Ogunquit

Members and Honorary Members

ANDROSCOGGIN COUNTY

MEMBERS

ANDREWS, SULLIVAN L., 138 Lisbon St., Lewiston
BELIVEAU, ROMEO A., 89 Pine St., Lewiston
BERNARD, ROMEO A., 144 Pine St., Lewiston
BOLSTER, WILLIAM W., 210 College St., Lewiston
BRIEN, MAURICE, 80 Pine St., Lewiston
BUKER, EDSON B., 80 Goff St., Auburn
BUSCH, JOHN J., 105 Elm St., Mechanic Falls
CALL, ERNEST V., 118 Pine St., Lewiston
CARON, FREDERICK J., 174 Bates St., Lewiston
CARTLAND, JOHN E., 117 Goff St., Auburn
CHAFFERS, WILLIAM H., 190 Bates St., Lewiston
CHENERY, FREDERICK L., JR., Monmouth
CLAPP, WALDO A., 376 Main St., Lewiston
CORRAO, FRANK P., 86 Pine St., Lewiston
DESAULNIERS, GEORGE E. D., 106 Chestnut St., Lewiston
DIONNE, MAURICE J., Brunswick
FAHEY, WILLIAM J., 17 Frye St., Lewiston
FORTIER, PAUL J. B., 190 Bates St., Lewiston
GAUVREAU, HORACE L., 82 Pine St., Lewiston
GERRISH, LESTER P., Lisbon Falls
GIGUERE, EUSTACHE N., 109 Cedar St., Lewiston
GOLDMAN, MORRIS E., 487 Main St., Lewiston
GOODWIN, RALPH A., 56 Dennison St., Auburn
GOTTLIEB, JULIUS, 49 Central Ave., Auburn
GRANT, ALTON L., JR., 133 Court St., Auburn
GROSS, LEROY C., 19 Goff St., Auburn
HAAS, RUDOLF, Cent. Me. Gen. Hosp., Lewiston
HANSCOM, OSCAR E., Greene
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HIEBERT, JOELLE C., 240 College St., Lewiston
HIGGINS, EVERETT C., 149 College St., Lewiston
HIRSHLER, MAX, 85 Pine St., Lewiston
JAMES, CHAKMAKIS, 133 College St., Lewiston
MARCOTTE, JOHN B., 280 Lisbon St., Lewiston
MARSTON, EDWIN J., 76 Goff St., Auburn
MILLER, HUDSON R., 11 Turner St., Auburn
MURPHY, D. JEROME, 126 College St., Lewiston
PEASLEE, CLARENCE C., 42 Goff St., Auburn
PIERCE, EDWIN F., 24 Frye St., Lewiston
PLUMMER, ALBERT W., Lisbon Falls
POULIN, J. EMILE, 198 Lisbon St., Lewiston
PRATT, HAROLD S., Livermore Falls
RAND, CARLETON H., 166 College St., Lewiston
RAND, GEORGE H., Livermore Falls
RENWICK, WARD J., 102 Goff St., Auburn
ROWE, GUNTHNER H., Livermore Falls
ROY, LEOPOLD O., 54 Pine St., Lewiston
RUSSELL, BLINN W., 98 Pine St., Lewiston
RUSSELL, DANIEL F. D., Leeds
SANSOUCY, JEROME A., 3900 13th St., N. E., Washington, D. C.
SCHNEIDER, GEORGE A., 198 Lisbon St., Lewiston
SWEATT, LINWOOD A., 48 Drummond St., Auburn
THOMAS, CAMP C., Greene
TWADDLE, GARD W., 57 Goff St., Auburn
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WEBBER, WALLACE E., 297 Main St., Lewiston
WILLIAMS, JAMES A., Mechanic Falls

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CARTER, LOREN F., Presque Isle
DAMON, ALBERT H., Limestone
DOBLE, EUGENE H., Presque Isle
DONOVAN, JOSEPH A., Houlton
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GIBSON, WILLIAM B., Houlton
GRAVES, RICHARD A., Presque Isle
GREGORY, FREDERICK L., Caribou
GRIFFITHS, EUGENE B., Presque Isle
GROW, WILLIAM B., Presque Isle
HAMMOND, H. HERBERT, Van Buren
HARVEY, THOMAS G., Mars Hill
HUGGARD, LESLIE H., Limestone
JACKSON, FRANK H., Houlton
KALLOCH, HERBERT F., Fort Fairfield
KIMBALL, HERRICK C., Fort Fairfield
KIRK, WILLIAM V., Eagle Lake
LARRABEE, FAY F., Washburn
MITCHELL, FREDERICK W., Houlton
SAVAGE, RICHARD L., Fort Kent
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SOMERVILLE, WALLACE B., Mars Hill
SWETT, CLYDE I., Island Falls

HONORARY MEMBERS

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SINCOCK, WILEY E., Caribou
UPTON, GEORGE W., Sherman

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BEACH, S. JUDD, 704 Congress St., Portland
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BICKMORE, HAROLD V., 723 Congress St., Portland
BISHOFFBERGER, JOHN M., Naples
BISHOP, LLOYD W., 211 Vaughan St., Portland
BRAMHALL, THEODORE C., 704 Congress St., Portland
BROWN, LUTHER A., 13 Deering St., Portland
BROWN, STEPHEN S., 22 Arsenal St., Portland
BURRAGE, THOMAS J., 142 High St., Portland
CARMICHAEL, FRANK E., 72 Deering St., Portland
CENTER, ERVIN A., Steep Falls
CLARKE, CHESTER L., 10 Congress Square, Portland
CLOUGH, DEXTER J., 10 Dow St., Portland
CONNEEN, LAWRENCE W., 131 State St., Portland
CRAGIN, CHARLES L., 831 Congress St., Portland
CUMMINGS, GEORGE O., 47 Deering St., Portland
CURTIS, HARRY L., 142 High St., Portland
DAVIS, HARRY E., 169 State St., Portland
DOOLEY, FRANCIS M., 53 Deering St., Portland
DORE, KENNETH E., Fryeburg
DORSEY, FRANK D., 52 Deering St., Portland
DRUMMOND, JOSEPH B., 62 State St., Portland
DYER, HENRY L., 27 Green Sq., Berlin, N. H.
EMERY, HARRY S., 721 Stevens Ave., Portland
EVERETT, HAROLD J., 308 Danforth St., Portland
FERGUSON, FRANKLIN A., 9 Deering St., Portland
FICKETT, JEROME P., Naples
FILES, ERNEST W., 201 State St., Portland
FISHER, STANWOOD E., 388 Spring St., Portland
FOLSOM, ERNEST B., 37 Payson St., Portland

FOSTER, ALBERT D., Bay Shore Drive, Falmouth Foreside
FOSTER, BENJAMIN B., 300 Danforth St., Portland
FOSTER, THOMAS A., 131 State St., Portland
GEER, GEORGE I., 756 Congress St., Portland
GEHRING, EDWIN W., 131 State St., Portland
GORDON, CHARLES H., 46 Deering St., Portland
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HALL, EARL S., 696 Congress St., Portland
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HANEY, ORMEL E., 74 Deering St., Portland
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HASKELL, ALFRED W., 142 High St., Portland
HATCH, LUCINDA B., 27 Deering St., Portland
HAWKES, RICHARD S., 21 Deering St., Portland
HAY, WALTER F. W., 131 State St., Portland
HILLS, LOUIS L., 816 Main St., Westbrook
HOLT, E. EUGENE, JR., 723 Congress St., Portland
HOLT, WILLIAM, 14 Deering St., Portland
HOWARD, HARVEY, Freeport
HUNT, CHARLES H., 60 Winter St., Portland
HUNTRESS, RODERICK L., 10 Congress Square, Portland
JAMIESON, JAMES G. S., 82 High St., Portland
JOHNSON, HENRY P., 32 Deering St., Portland
JOHNSON, OSCAR R., 18 Deering St., Portland
KUPELIAN, NESSIB S., Pownal
LAMB, HENRY W., 131 State St., Portland
LAPPIN, JOHN J., 171 State St., Portland
LEIGHTON, ADAM P., 192 State St., Portland
LITTLE, ALBION H., 692 Congress St., Portland
LOGAN, G. E. C., 131 State St., Portland
MACDONALD, H. EUGENE, 21 Deering St., Portland
MARTIN, RALF S., 58 Deering St., Portland
MARTIN, THOMAS A., 131 State St., Portland
McADAMS, WILLIAM R., 704 Congress St., Portland
McDERMOTT, LEO J., 151 Vaughan St., Portland
MELNICK, JACOB, 333 Congress St., Portland
MILLER, THOR, 752 Main St., Westbrook
MILLIKEN, JOHN S., 21 Veranda St., Portland
MONKHOUSE, WILLIAM M., 62 Bowdoin St., Portland
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MOULTON, ALBERT W., 180 State St., Portland
NEEDELMAN, WILLIAM R., 312 Congress St., Portland
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O'DONNELL, EUGENE E., 32 Deering St., Portland
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PATTERSON, JAMES, 614 Highland Ave., So. Portland
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PORTER, JOSEPH E., 22 Arsenal St., Portland
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SKILLIN, WALDO T., So. Portland
SMITH, FRANK A., 343 Main St., Westbrook
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SWIFT, HENRY M., 42 Wood Rd., Cape Cottage
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THAXTER, LANGDON T., 31 Deering St., Portland
THOMPSON, PHILIP P., 704 Congress St., Portland
TIBBETTS, GEORGE A., 519 Cumberland Ave., Portland
TOBIE, WALTER E., 3 Deering St., Portland
TOUGAS, RAYMOND, Brunswick
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UPHAM, ROSCOE C., 15 Crescent St., Biddeford
WALKER, MARIBEL H., Cape Cottage
WARD, JOHN V., 45 Deering St., Portland
WARREN, MORTIMER, 22 Arsenal St., Portland
WEBB, HAROLD R., Brunswick
WEBBER, ISAAC M., 29 Deering St., Portland
WEBBER, M. CARROLL, 735 Stevens Ave., Portland
WEBSTER, FRED P., 10 Congress Square, Portland
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WELCH, FRANCIS J., 44 Deering St., Portland
WELLINGTON, J. FOSTER, 655 Congress St., Portland
WESCOTT, CLEMENT F., 201 State St., Portland
WHITNEY, HARLAN R., 655 Congress St., Portland
WHITTIER, ALICE A. S., 143 Neal St., Portland
WIGHT, DONALD G., 30 Mitchell Rd., So. Portland
WILSON, CLEMENT S., Brunswick
WOODMAN, ARTHUR B., Falmouth Foreside
WOODMAN, GEORGE M., 826 Main St., Westbrook
ZOLOV, BENJAMIN, 296 Congress St., Portland

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PUDOR, GUSTAV A., 142 High St., Portland
ROBINSON, EDWARD F., Falmouth
SMITH, OWEN, 692 Congress St., Portland
WHEET, FREDERICK E., 773 Main St., Westbrook

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FLOYD, ALBION E., New Sharon
MOULTON, JOHN H., Rangeley
PRATT, GEORGE L., 7 Main St., Farmington
THOMPSON, CECIL F., Dodge Rd., Phillips
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ZIKEL, HERBERT M., Wilton

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HIGGINS, ROYAL G., Bar Harbor
HOLT, HIRAM ALLEN, Winter Harbor
KNOWLTON, CHARLES C., Ellsworth
KOPFMANN, HARRY, Deer Isle
MILLSTEIN, HYMAN, Southwest Harbor
MORRISON, CHARLES C., JR., Bar Harbor
NOYES, B. LAKE, Stonington
PARCHER, ARTHUR H., Ellsworth
PARCHER, GEORGE, Ellsworth
THEGEN, EDWARD, Bucksport
WAKEFIELD, RALPH W., Bar Harbor

HONORARY MEMBER

PHILLIPS, JOSEPH D., Southwest Harbor

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ALEXANDER, GEORGE W., 128 Dresden Ave., Gardiner
BAUMAN, CLAIR S., 177 Main St., Waterville
BISSON, NAPOLEON, 29 Common St., Waterville
BLISH, M. ELEANOR, State House, Augusta
BREARD, JOSEPH A., 15 Summer St., Waterville
CAMPBELL, GEORGE R., 175 Water St., Augusta
CARTER, FREDERICK R., 43 Sylvan Rd., So. Portland
CATES, SAMUEL C., East Vassalboro
CLASON, SILAS O., Gardiner
COBB, WILLIAM O., Gardiner
COOMBS, GEORGE A., 283 Water St., Augusta
CROMWELL, CHARLES D., Central Maine Sanatorium, Fairfield
ELKINS, HARRY, Augusta State Hospital, Augusta
GIDDINGS, PAUL D., 284 Water St., Augusta
GINGRAS, ADOLPHE J., 99 Water St., Augusta
GOODRICH, BLYNN O., 165 Main St., Waterville
GOUSSE, WILLIAM L., Fairfield
GUITE, L. ARMAND, 27 Main St., Waterville
HARLOW, EDWIN W., 177 Main St., Waterville
HERRING, LEON D., Winthrop
HILL, FREDERICK T., 177 Main St., Waterville
HILL, HOWARD F., 177 Main St., Waterville
HIRSCHBERGER, CELIA, 44 Main St., Waterville
JACKSON, ELMER H., 304 Water St., Augusta
KAGAN, SAMUEL H., 283 Water St., Augusta
KENNEY, CLARENCE J., Veterans' Administration, White River Jct., Vt.
KOBES, HERBERT R., State House, Augusta
LIBBY, ARA B., 295 Water St., Gardiner
LUBELL, MOSES F., 50 Roosevelt Ave., Waterville
MANN, LEWIS L., 177 Water St., Augusta
MARQUARDT, MATTHIAS, Augusta State Hospital, Augusta
McCOY, THOMAS C., 90 Main St., Waterville
McKAY, ROLAND L., 284 Water St., Augusta
McLAUGHLIN, CLARENCE R., 345 Water St., Gardiner
McQUILLAN, A. H., 177 Main St., Waterville
MERRILL, PERCY S., 82 Elm St., Waterville
MITCHELL, ROSCOE L., 111 Western Ave., Augusta
MOORE, ARNOLD W., 31 Deering St., Portland
MORRELL, ARCH H., State House, Augusta
NEWCOMB, CHARLES H., Clinton
O'CONNOR, WILLIAM J., 341 Water St., Augusta
ODIORNE, JOSEPH E., Coopers Mills
PARIZO, HARRY L., 2 Silver St., Waterville
PIPER, JOHN O., 177 Main St., Waterville
POULIN, JAMES E., 177 Main St., Waterville
PRIEST, MAURICE A., 283 Water St., Augusta
PROVOST, HELEN C., 48 Green St., Augusta
REYNOLDS, RALPH L., 101 Main St., Waterville
RISLEY, EDWARD H., 27 College Ave., Waterville
ROSENBERG, NATHAN, Veterans' Administration, Togus
SMALL, MORTON M., 28 Common St., Waterville
SOMMERFELD, JURT A., Gardiner
STUBBS, RICHARD H., 133 State St., Augusta
TURNER, OLIVER W., 37 Stone St., Augusta
TURNER, RODNEY D., 30 Grove St., Augusta
TYSON, FORREST C., Augusta State Hospital, Augusta
VENTIMIGLIA, WILLIAM A., Veterans' Administration, Togus
WHEELER, FRED E., 65 Temple St., Waterville
WILLIAMS, EDMUND P., Oakland
WILLIAMS, FRANCIS T., Veterans' Administration, Togus
YOUNG, WILLIAM J., Yonkers, N. Y.

KNOX COUNTY

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CAMPBELL, FRED G., Warren
CARSWELL, JAMES, JR., 6 Sea St., Camden
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FOSS, ALVIN W., 11 Beech St., Rockland
FROHOCK, HORATIO W., 10 Summer St., Rockland
FULLER, ABBOTT J., Pemaquid
GREEN, ARCHIBALD F., 60 Elm St., Camden
HALL, WALTER D., 407 Main St., Rockland
HUTCHINS, JAMES G., 59 Elm St., Camden
JAMESON, C. HAROLD, 465 Main St., Rockland
KELLER, BENJAMIN H., 407 Main St., Thomaston
LEACH, CHARLES H., Pownal
NORTH, CHARLES D., 38 Union St., Rockland
POLISNER, SAUL R., 13 Mountain St., Camden
POPPLESTONE, CHARLES B., 465 Main St., Rockland
SHIELDS, VICTOR H., North Haven
SOULE, GILMORE W., 80 Broad St., Rockland
TWEEDIE, HEDLEY V., 407 Main St., Rockland
WEISMAN, HERMAN J., 76 Limerock St., Rockland

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COOMBS, GEORGE H., Waldoboro

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DENNISON, CHARLES N., Waldoboro
DOBLE, MIRIAM, Bath
FERNALD, H. E., East Boothbay
FULLER, EDWIN M., 119 Front St., Bath
FULLER, EDWIN M., JR., 108 Front St., Bath
GRANT, HUGH D., 141 Front St., Bath
GREGORY, PHILIP O., 6 Commercial St., Boothbay Harbor
HAMILTON, VIRGINIA C., 900 Washington St., Bath
KERSHNER, WARREN E., 119 Front St., Bath
LAUGHLIN, JAMES W., Newcastle
MILLS, NATHANIEL, Bath
MORIN, HARRY F., 72 Front St., Bath
OWEN, ALBERT S., 832 Washington St., Bath
PARSONS, NEIL L., Damariscotta
PRATT, EDWIN F., 7 Main St., Richmond
SMITH, JOSEPH I., 73½ Front St., Bath
SNIPE, LANGDON T., 112 Front St., Bath
SOMMERS, ROBERT Richmond
STETSON, RUFUS E., Damariscotta

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PARSONS, WILLIAM H., Damariscotta

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DAVIDSON, DAVID, West. Me. Sanatorium, Greenwood Mt.
DAVIDSON, GISELA K., West. Me. Sanatorium, Greenwood Mt.
DEFOE, GARFIELD G., Dixfield
ELSEMORE, DEXTER E., Dixfield
GEYERHAHN, GEORGE, 6 Albany St., So. Portland
GREENE, JOHN A., 96 Congress St., Rumford
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KAY, EDWIN, 671 Main St., Lewiston

LAWRENCE, HOMER E., Bethel
LESLIE, FRANK E., Andover
MacDOUGALL, JAMES A., 303 Penobscot St., Rumford
McCARTY, EUGENE M., 82 Maine Ave., Rumford
MOODY, HARRY A., 150 Congress St., Rumford
MOORE, BERYL M., Oxford
NELSON, CHELSEY W., Norway
NOYES, HARRIETT L., 114 Congress St., Rumford
OESTRICH, ALFRED, Mexico
PEARSON, HENRY, Brownfield
ROWE, WILLIAM T., 250 Penobscot St., Rumford
ROYAL, ALBERT P., 82 Main Ave., Rumford
SMALLEY, FRED L., Lebanon, N. H.
STANWOOD, HAROLD W., 5 Franklin St., Rumford
STAPLES, IVAN W., Norway
STEWART, DELBERT M., So. Paris
TIBBETTS, RAYMOND R., Bethel

HONORARY MEMBERS

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STURTEVANT, JAMES S., Dixfield

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AMES, FORREST B., 489 State St., Bangor
BLAISDELL, CARL E., 47 Broadway, Bangor
BURGESS, CHARLES H., 239 Hammond St., Bangor
CLEMENT, JAMES D., 77 Essex St., Bangor
CLOUGH, DEXTER J., 2ND, 209 State St., Bangor
CRAIG, D. ALLAN, 489 State St., Bangor
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DUNHAM, RAND A., East Millinocket
EMERSON, W. MERRITT, 131 State St., Bangor
FELLOWS, ALBERT W., 45 Ohio St., Bangor
GOODRICH, EDWARD P., Winterport
GUMPRECHT, WALTER R., 116 State St., Bangor
HALL, WALTER C., Orono
HALL, WALTER L. H., 18 High St., Old Town
HAMMOND, WALTER J., State Hospital, Bangor
HEDIN, CARL J., State Hospital, Bangor
HERLIHY, EDWARD L., 159 State St., Bangor
HIGGINS, GEORGE I., Newport
HILL, ALLISON K., 113 Somerset St., Bangor
HORTON, GEORGE H., Hermon
HUNT, BARBARA, State Board of Health, Jackson, Miss.
HUNT, HARRISON J., 162 French St., Bangor
KNOWLTON, HENRY C., 47 Broadway, Bangor
LETHIECQ, JOSEPH A., 115 Wilson St., Brewer
LEZBERG, JOSEPH, 28 Main St., Bangor
LIBBY, HAROLD E., Lincoln
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MADDAN, MARTIN C., Old Town
MANSFIELD, BLANCHE M., 191 State St., Bangor
MASON, LUTHER S., 109 State St., Bangor
McKAY, HUGH G., Old Town
McNAMARA, WESLEY C., Lincoln
McNEIL, HARRY D., 58 Hammond St., Bangor
McQUOID, ROBERT M., 39 Columbia St., Bangor
MILLINGTON, PAUL A., 44 High St., Newport
MOISE, THEODORE S., 42 Fourth St., Bangor
MOULTON, MANNING C., 150 State St., Bangor
MUNCE, RICHARD T., 205 French St., Bangor
PEARSON, JOHN J., Old Town
PETERS, WILLIAM C., 45 State St., Bangor
PURINTON, WATSON S., 15 Ohio St., Bangor
PURINTON, WILLIAM A., 39 High St., Bangor
RIDLON, MAGNUS F., 99 Broadway, Bangor
ROBINSON, HARRISON L., 136 Hammond St., Bangor
RUHLIN, CARL W., 268 State St., Bangor
SANGER, EUGENE B., 111 State St., Bangor
SCHRIVER, ALFRED H., 16 Parkview Ave., Bangor
SCHURMAN, HANS, Dexter
SCRIBNER, HERBERT C., 259 Union St., Bangor
SILSBY, SAMUEL S., 11 Ohio St., Bangor
SKINNER, PETER S., 112 Ohio St., Bangor
SKOLFIELD, EZRA B., East Corinth
SMALL, AMOS E., 31 Central St., Bangor
SMITH, LeROY H., Winterport
STEBBINS, ARTHUR P., State Hospital, Bangor
STROUT, ARTHUR C., Dexter
TAYLOR, CORNELIUS J., 18 State St., Bangor
TAYLOR, HERBERT L., Dexter
THERIAULT, LOUIS L., Old Town
THOMAS, CALVIN M., 142 N. Main St., Brewer
THOMPSON, HERBERT E., 489 State St., Bangor
THOMPSON, JOHN B., 316 Center St., Bangor
VICKERS, MARTYN A., 268 State St., Bangor
WEATHERBEE, GEORGE B., Hampden Highlands
WEBBER, MERLON A., Pittsfield
WEISZ, HANS, Howland
WEYMOUTH, FRANK D., 46 No, Main St., Brewer
WHALEN, HENRY E., Dexter
WHITWORTH, JOHN E., 49 Hammond St., Bangor
WOODCOCK, ALLAN, 35 Second St., Bangor
WRIGHT, LaFOREST J., 39 W. Broadway, Bangor
YOUNG, ERNEST T., Millinocket

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BAYARD, CLAYTON H., Main St., Orono

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CARDE, ALBERT M., Milo
DORE, GUY E., Guilford
MacDOUGAL, WILBUR E., Dover-Foxcroft
PRITHAM, FRED J., Greenville Junction
STANHOPE, CHARLES N., Dover-Foxcroft
STUART, RALPH C., Guilford
VALENTINE, JOHN B., Dover-Foxcroft

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MERRILL, ELMER D., Dover-Foxcroft

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GILBERT, PERCY E., Madison Ave., Madison
HUMPHREYS, ERNEST D., 91 Main St., Pittsfield
HUTCHINS, EUGENE L., No. New Portland
LORD, MAURICE E., 220 Water St., Skowhegan
MARSTON, HENRY E., No. Anson
MILLIKEN, WALTER S., 35 Maple St., Madison
NORRIS, LESTER F., Maple St., Madison
PHILBRICK, MAURICE S., 292 Water St., Skowhegan
REED, HOWARD L., 43 Western Ave., Madison
SMITH, HARRY W., Norridgewock
STINCHFIELD, WALTER S., Court St., Skowhegan
WALTERS, WILSON H., 16 Summit St., Fairfield
YOUNG, GEORGE E., Water St., Skowhegan

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MOULTON, CHARLES A., Hartland

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READ, SETH H.,	Belfast
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Index to Advertisers

Blackwell, Elmer N.	XV
Brewing Industry Foundation	VII
Camel Cigarettes	VI
Coca-Cola	XVI
Crane Discount Corporation	XV
Frye Company, Geo. C.	V
Gay Private Hospital	XVII
Holland-Rantos Co., Inc.	IX
Hospital Pharmacy, Inc.	XV
Jones' Private Sanitarium	XVII
Leighton's Hospital, Dr.	XVII
Lilly & Company, Eli	XIV
Maine Surgical Supply Co.	XVI
Marks Printing House	XV
Mead Johnson & Company	XIX
Medical Auditing Counsel	127
Nestle's Milk Products, Inc.	III
Parke, Davis & Company	X
Petrogalar	III
Philip Morris & Co.	VIII
Physicians Casualty Association	V
Prentiss Loring, Son & Co.	XV
S. M. A. Corporation	XI
Squibb & Son, E. R.	XIII
State Street Hospital	XVII
Winthrop Chemical Co., Inc.	XII
Wyeth & Brother Inc., John	II
Zemmer Company, The	118

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The Journal
of the
Maine Medical Association

Volume Thirty-four Portland, Maine, July, 1943 No. 7

*Presidential Address**

Carl H. Stevens, M. D., Belfast, Maine

Members of the Maine Medical Association, Ladies and Guests:

Since the 90th Annual Session of this Association at Poland Spring last June, many changes have taken place with many of them of interest to the Medical Profession.

As you all know the number of medical meetings, national, state, and county have been greatly reduced because of general conditions.

During the past year your Council has met five times, including today's meeting, and at the Fall Session in Waterville voted to have a one-day business session, with one or two speakers, as suggested at the summer meeting of the Council. It was voted to hold that meeting today that the business of the Association might be carried on by the Council, Delegates from County Medical Societies, and give the members an opportunity to attend at least one meeting a year.

When War was declared there were 13,000 physicians serving the armed forces of the U. S. By the end of 1942—42,000 U. S. physicians were in Military Service. During 1943—11,000 more will be added.

When war was declared by the United States there were about 900 physicians in Maine and on May 31, 1943, there were 748 members of the Maine Medical Association. Of this 748 members, 176 or 23.5% are in Military Service and 31 are honorary. This means we have only 541 active, dues paying members, which also means a real reduction in the Association income, as Military and Honorary members are exempt from dues.

During 1942, under the volunteer system, Maine more than furnished its full quota of physicians to the Military Forces, a fact which makes us justly proud. As most of these men were very active in practice the burden of professional work upon those physicians at home has been greatly increased.

Many of these home front physicians have, in addition to their actual professional work upon patients, given many hours of their time to some other phases of the war effort, such as Selective Service, Induction Board, Procurement and Assignment Service for Physicians, First Aid Teaching, Blood Plasma

* Presented at the Luncheon Meeting of the Maine Medical Association, House of Delegates, Sunday, June 20, 1943, Augusta, Maine.

Clinics, Emergency Medical Defense, and other gratuitous services in an attempt to do their bit in this War.

Boston physicians had the opportunity to demonstrate the value of preparedness in Emergency Medical Service during and following the Cocoanut Grove Fire Disaster. Those of us at home should prepare ourselves as well as possible in matters pertaining to Emergency Medical Service, that we may not only instruct others concerning this subject, but that we may render better service to a greater number when warfare in any form reaches the shores of this country, or any country in which we may be asked to render service. If you will take the time to read a recent article by James M. Landis, National Director of Civilian Defense, I think you will agree that preparedness from a medical point of view is essential to the welfare of our civilian population, our industries, and our winning of this war.

Today's luncheon program was arranged so that we on the home front might secure some real information concerning the Civilian Defense Program in this region of the Country and in this State, especially from an emergency medical viewpoint.

We are fortunate in securing two speakers on this subject, one from Boston, and one from Portland.

At this time it is my pleasure to present our State Chief of Emergency Medical Service, who after telling us what he may of the set-up in this State will introduce the Regional Medical Officer for Civilian Defense. I present Albert W. Moulton, M. D., State Chief of Emergency Medical Service. (Remarks by Dr. Moulton, and Dr. Reggio's address will be published in a later issue of the JOURNAL.)

On behalf of our Association, I wish to thank Dr. Moulton and Dr. Reggio for their very interesting talks, and Dr. Reggio for coming to Maine and impressing upon us the importance of a well prepared medical home front.

During the past year, four members of our Association have completed fifty years in the practice of medicine. To have completed fifty years in the practice of medicine and surgery as an M. D., is no small attainment, and in recognition of this accomplishment it is the custom of our Association to present such a member with a medal that not only signifies his years of professional service to the public, but also shows that his work has been honored by his associates. Unfortunately none of the recipients of this year's medals are able to be present, but on behalf of the Maine Medical Association it gives me great pleasure to read to this audience the names of these men whose medals will be mailed to them:

Everett B. Currier, Phillips, Maine (Franklin County member), graduated from the College of Physicians and Surgeons, Baltimore, 1893. Doctor Currier died suddenly on May 22, 1943, but his medal will be mailed to Mrs. Currier.

Royal G. Higgins, Bar Harbor, Maine (Hancock County member), graduated from Hahnemann Medical College, Philadelphia, 1892.

Langdon T. Snipe, Bath, Maine (Lincoln-Sagadahoc County member), graduated from Columbia University College of Physicians and Surgeons, New York, 1893. President of the Maine Medical Association, 1922-1923.

Oliver W. Turner, Augusta, Maine (Kennebec County member), graduated from Jefferson Medical College, Philadelphia, 1893.

On behalf of our Association, I wish to express its thanks to the Council, the Delegates, County Secretaries, Members of Standing and Special Committees, and to our delegate to the American Medical Association, Thomas A. Foster, M. D., for their efficient work during the past year. We should be especially grateful to Herbert E. Locke, Esq., an honorary member of, and Attorney for this Association, for his excellent work in the interest of the profession at the 1943 session of the Maine Legislature.

To our Secretary-Treasurer of the Association and Editor of the JOURNAL, Frederick R. Carter, M. D., and to Assistant Secretary, Esther M. Kennard, we are deeply grateful for another year of unfailing and efficient service in the interest of our Association.

Continued on page 134

*Hospital Care as a Department of Health and Welfare Problem**

By Herbert R. Kobes, M. D., Director of Hospital Aid, Department of Health and Welfare, Augusta, Maine

Hospital care for persons in whom the State of Maine has an interest can be discussed from two points of view. First, we consider those individuals for whose general care the State is directly responsible.

This group is a rather limited one and consists mainly of children legally committed to the State by the Courts and of individuals and families who have no legal town settlement in Maine and are in such financial distress that the State must furnish direct relief. The State assumes complete responsibility for any aid needed by these individuals and included in this aid is hospital care. For committed children the Division of Child Welfare of the Bureau of Social Welfare gives authorization for hospital care at the regular ward rate or at a rate agreed upon. For cases with a State settlement or no settlement the Division of Poor Relief assumes responsibility for the care and also pays full ward rates. In most hospitals ward rates plus charges for extras (X-ray, laboratory, special treatment, and so forth) are paid but in one hospital at least a flat rate is used and thus the item for extras does not come up.

The Division of Poor Relief reimburses the town of residence of the individual for hospital care which has been authorized by the Overseer of the Poor of the town of residence. Thus the hospital primarily deals with the local town authorities even though the case is a State dependent. The Division of Poor Relief feels that local resources should be developed and used as extensively as is consistent with good service. With this in mind it may frequently be possible to hospitalize individuals in small local hospitals whenever in these hospitals adequate medical care is available to treat the patient. It is recognized that there is considerable variation in the cost of administering large hospitals as compared with small hospitals. In general the daily cost of care in small hospitals tends to be somewhat greater than in large urban general hospitals. This fact is recognized by the Division of Poor Relief and it is felt that agreements with individual hospitals need to be made regarding the cost of care in the different hospitals. Among other things this will mean that the hospitals in order to arrive at an agreement with the State will need to keep accurate costs of ward service as distinguished from private service. Because of changes in costs of operation, annual review of the cost of care should be made and the daily cost of care for one fiscal year could be applied for the following fiscal year. Criticism might be made, that in a year when costs are rising markedly, that care during that year based on previous accounting would pay the hospital inadequately for the care given during the current year. This criticism can easily be met if the hospitals will remember that there are also periods when the costs decrease and thus during such a year the hospital will be paid in excess of the cost during that particular year and, in general, this method of arriving at a fair daily ward rate will be equitable to all concerned.

The Division of Poor Relief is very anxious for the hospitals, especially the local small community hospitals, to determine the actual daily ward cost so that agreements can be made with the hospitals. The rate which will be set should be an over-all rate so that extras are not charged for separately. It might even be feasible to apply such a rate to the other patients who are in the hospital because our experience has been that complaints against hospital costs are frequently centered about the high cost of extras and if an over-all rate figured on a hospital's annual expense would be used then patients would feel much more satisfied.

The second and much larger group of individuals receiving hospital care and in whom the State has an interest are those persons who receive the benefits of the Hospital Aid Fund. The majority of these individuals are

* Read at the annual meeting of the Maine Hospital Association held at Augusta, September 16, 1942.

not in any way people in whom the State need have any legal responsibility. The presence of a Hospital Aid Law and Appropriation among the Laws of Maine is evidence that the legislators have a keen humane interest in those residents of the State who are in financial distress because of the expensive care which comes about by illness necessitating hospitalization. At the present time the Hospital Aid Appropriation is $300,000. per year and is available to aid hospitals in caring for individuals *who have not received direct relief in the ninety days prior to admission to the hospital.* These individuals must either have a settlement in the State or have lived in Maine for one year prior to the time of making application. The patient or responsible relatives must be financially unable to pay in full a ward rate which according to the current regulations has been set by Hospital Aid at $3.00 per day. We also meet the statement "in every case an effort should be made to get the patient or relative to make partial payment *according to his financial ability to do so even though it may be a small amount.*" This assistance is given to hospitals in order that they may give necessary treatment to individuals of the State who are managing to support themselves and their families but can not meet the burden of rather large hospital bills without some financial assistance. If there were no State administered Hospital Aid, in all probability the majority of these individuals would need to obtain direct relief from the town in order to meet the cost of care or if this were impossible or not desirable in a good many instances the hospitals themselves would need to bear the cost of the hospitalization.

It is felt by the administration of the Department of Health and Welfare that the State's contribution of $300,000. per year is all that should be paid to the hospitals for individuals who are eligible to receive Hospital Aid. This statement brings up the fact that recipients of public assistance such as Aid to Dependent Children, Aid to the Blind and Old Age Assistance are eligible to receive Hospital Aid. The State feels that it should assume no further obligation toward meeting the hospital bills for these individuals. Efforts have previously been made to have financial grants given such people receiving public assistance increased to meet the balance of the cost of care over and above that paid by the State through the Hospital Aid Appropriation. The argument may be advanced that these recipients of public assistance are charges of the State but according to Chapter 253 of the Laws of Maine, "An Act Relating to Pauper Settlements," Section I, "During the period that a person is supported in whole or in part by old age assistance or aid to the blind, he and those who derive their settlement from him shall not acquire or lose a pauper settlement, nor be in the process of acquiring or losing a pauper settlement." We realize that if the hospitals look at the problem from the point of view of the *individual patient* that there may be a deficit which needs to be made up since the State has not paid up the whole of the hospital bill. Hospital Aid, however, is an appropriation which is entirely an *AID* to the hospitals and there is no implication that the State is expecting to meet the complete hospital bill for the individual. That it would be a fallacy for the State to make up this balance can quite easily be established. The annual reports from the various hospitals do not show a deficit equivalent to the amounts which the hospitals failed to obtain in those cases where Hospital Aid was paid and no other resources met the full obligations contracted by hospitalization.

Other resources such as endowments, higher charges for private service and other services rendered have largely made up the apparent deficit. It does not seem logical to us for hospitals that are operating on a nonprofit or charitable basis to represent as deficit the amounts of uncollected bills. Balancing of hospital books, as is true of other business endeavors, consists in checking the income against expenditures, not possible income against expenditures.

The hospitals, no doubt, have been pleased to note that during the past fiscal year the average payment from the Hospital Aid Fund on a per diem basis was in excess of $2.00; the variation being from $1.95 to $2.30. It is felt that in all likelihood the present appropriation will be adequate to meet the needs of the hospitals at the present

time because of favorable business and industrial conditions within the State.

The matter of reimbursement from the various hospitals has caused considerable discussion. At the present time the Hospital Aid rules state that "in cases where payments by a patient, plus payments by Hospital Aid Fund exceed $3.00 a day, the Hospital Aid Fund should be reimbursed by the hospital for the amount it received in excess of $3.00." It is recognized that this $3.00 rate is not a fair one since at the present time hospital costs are over and above $3.00 per day in most hospitals. In addition, the matter of extras brings about many problems. If the hospitals would be able to establish an over-all ward rate which includes all extra charges then a new figure for determining reimbursement can be worked out. It may be possible to arrive at a fair average figure which will be applied to all hospitals or if the various hospitals show too much variation in their per diem cost then different rates may need to be established for each hospital and the rate may need to change annually depending on the cost of care in the particular hospital during the preceding year. The matter of reimbursement needs to be included in the regulations for administering Hospital Aid because obviously the hospital should not be able to collect from the State when adequate amounts for care are paid by the patient or some other resource, either at the time of hospitalization or at a later date. The Hospital Aid Division is expecting to revise its regulations in a manner equitable to the State, the patients and the hospitals and the above suggestions may possibly be considered in this revision.

Because of the large annual appropriation it it very likely that auditing of this $300,000 account by the State may be necessary to arrive at the proper figures both for original payments and reimbursements.

Because it has been found that one- and two-day hospitalizations frequently are paid for in full by the patients or relatives, it is being suggested that Hospital Aid be available only to individuals who are hospitalized for three or more days. This is consistent with the philosophy behind Hospital Aid. The hospitals will not sustain any loss if these short stay cases are eliminated because the State will pay the full amount of money which is available in the Hospital Aid Fund regardless of whether or not these individuals are counted. The hospitals may sustain an apparent loss in a few individual instances but this will be made up by an increase of the per diem rate for the cases who are in the hospital for a longer period of time. Thus, neither the State nor the hospitals are in the position to lose anything by this procedure and surely a great deal of saving in administrative costs can be affected.

The above suggestions will necessitate the hospitals holding applications for Hospital Aid for a few days in order to determine how long the individual will be hospitalized. This should be of advantage to the hospital because it will give the finance office in the hospital an additional period of time to determine whether or not the individual is really eligible for Hospital Aid. One of the instructions to the hospitals regarding applications is as follows: "Phone or write the Overseer of Poor in the town or city where the applicant lives to determine whether or not the family has received any town aid. If you find that the applicant or his immediate family has been receiving assistance from the town within the past three months, ask the Overseer of the Poor to accept the responsibility of the treatment." We are quite certain that this procedure is not carried out in a good many instances because just a cursory investigation by the field workers of the Bureau of Social Welfare establishes, in a good many instances, the fact that the individual is receiving town assistance and therefore the case needs to be denied.

If the hospitals were more careful in giving the correct diagnosis and the probable length of time the patient would be in the hospital, the Hospital Aid Division would quite frequently be aided in its work, especially when reports from the field come in indicating that the field worker, who is a non-medical person, states that the family seems able to pay for care in full. Quite frequently if it is known that a long period of care is required, the Hospital Aid Division may agree with the hospital rather than the worker. It would almost seem possible from a medical point of view to obtain from the

physician caring for the patient his working diagnosis within a few days after the patient is admitted and also *his* estimate of the length of stay in the hospital.

Another change which will probably be an equitable one concerns the charges made against the Hospital Aid Fund in the interest of new-born infants. The present procedure is to have hospitals request a payment for a new-born infant's hospital days along with the mother's and the infant is considered in individual case. Investigation shows that the hospitals in this State are charging private cases no more than $1.00 per day for the care of new-born infants. Obviously it is a definitely unsound policy for the State to be paying more for Hospital Aid cases than for private cases. With this in mind we are considering counting the infant days separately from the other patient days and charging off against the infant days a stated amount which will not be more than $1.00 per day. Then the allotment for other cases will be figures against the remaining amount of money available.

The Hospital Aid Division is endeavoring to administer this fund in a completely equitable manner. It is felt that the hospitals receive very definite benefit from the fund and, therefore, all hospitals should feel that they have a community responsibility and thus serve as many individuals within a community by accepting eligible patients to their hospitals under the Hospital Aid appropriation. This will tend to make their hospitals much more COMMUNITY hospitals than they have been in some instances. Some of the larger urban hospitals have had to accept a good many cases coming from towns where there is a community hospital. This throws an unwarranted load on these large general hospitals and, of course, means that the community hospital which was originally founded to help the members of the community is not bearing its responsibility. With the decreased availability of medical care all means should be used to make available to the members of the community the best care which can be obtained in the community. The hospitals can rest assured that the State Department of Health and Welfare will do all in its power to carry out the various programs in a manner which will be of maximum benefit to the public.

Presidential Address—Continued from page 130

Personally my chief feeling this afternoon is one of regret that I have been unable to do more for the betterment of the Association. However, it is a relief that the year's work is ended. I have enjoyed my associations during my term of office and appreciate the honor of having served as President of the Maine Medical Association.

May our members now and in the future in Military Service soon be returned to their homes, their professional duties at home, and to this or other State Associations, that they may assist in promulgating the objects for which Medical Associations are organized, namely; "To promote the science and art of medicine, the protection of public health, and the betterment of the medical profession."

Thanking you, and if there are no other matters to be presented at this time, I declare this meeting adjourned.

(From "Cancer and Public Relations," Isaac F. Marcosson, Director of Public Relations, Memorial Hospital, New York City: Bulletin American Society for Control of Cancer, vol. 25, No. 2, page 16, Feb., 1943).

"One final conclusion; the cancer educational campaign, to fulfill its complete purpose, must be a fifty-fifty proposition. The agencies for the conservation of human life are doing their utmost to spread the gospel of early diagnosis and treatment. Clinics have become numerous and are easily accessible. Thanks to the propaganda, cancer symptoms are widely known. It is up to the public to do its share in heeding the advice so widely and generously bestowed. Intelligent capitalization of this advice will make for the safeguarding of the national health."

OSCAR F. LARSON, M. D.

President Maine Medical Association

1943 - 1944

Oscar F. Larson, M. D.

The incoming president of our Association is well known to practically all of its members.

Doctor Larson was born in Monson, Maine, April 6, 1881. His early education was received at Monson Academy. He was graduated from the Albany Medical School in 1905 and interned at the Hudson River State Hospital. He practiced in Monson, Maine, for two years and then moved to Jonesport where he practiced for six years. In 1913, he took a post-graduate course in New York. Doctor Larson has been in active practice in Machias, Maine, since 1914. In addition to private practice he has served as Medical Officer in Charge, U. S. Public Health Service, Relief Station, in Machias. He has also been county medical examiner for several years.

Doctor Larson has been active in the Maine Medical Association and for three years has been a member of the council, the last year being chairman.

He was married in 1907 to Martha M. Cross of Belfast, Maine. By this marriage he had one son, Capt. Thurman A. Larson, M. C., U. S. Army. In 1913, Doctor Larson was married to Josie Sawyer Woodward of Jonesport. They have two children, Capt. Karl V. Larson, M. C., U. S. Army, and Virginia M. Larson, student laboratory technician at the Eastern Maine General Hospital, Bangor, Maine.

The Association is fortunate in having as its president in these trying times a man as well qualified as Doctor Larson. We predict a successful administration.

The President's Page

To the Members of the Maine Medical Association:

The annual meeting of the Maine Medical Association, 1943, is past history; perhaps if we had stretched the cloth a bit, the old pattern could have been used with more general satisfaction, but whether it could or not, let us one and all work for the future success of our association.

In bestowing upon me the great honor of being your President for the ensuing year, I feel deeply grateful and shall try to be worthy of that honor. In order that I may become better acquainted with old, and with the hope of meeting new friends, I shall visit at least once every county Society in this state of ours if within my power to do so.

There is in this country today a group of "Theorists" who claim to believe in a Medical Utopia which will give complete medical care to all people, everywhere, but which can only be attained by an elaborate, costly, bureaucratic control of the practice of medicine, but you and I know that this is practically impossible and excessively expensive, as are all other politically controlled bureaus. Today the doctor is way ahead of good roads, markets, and other conveniences in the sparsely settled districts of our state and nation. He is supplying human needs in a humane manner from pole to pole. We doctors have our shortcomings, but they are human ones, and, for that reason, we ourselves should be more interested in curing them than anyone else. Therefore, we should live with an open mind ready for constructive criticism and give more and better service.

It is our business to see that from a medical standpoint people get proper service. I commend to the members of our association that portion of our constitution and by-laws which says, "the purposes of this association are to promote the art and science of medicine, the protection of the Public Health, and the betterment of the medical profession. That means you and me, let us keep it in mind.

Probably at no time in the history of our profession have we been confronted by such momentous problems as are facing us today. If we stoop to mere controversy and bickerings, to charge and counter-charge, we find only vindictiveness and retaliation, with the result that in spending so much time in trying to show up the faults of others on the outside, we forget to try to better and correct our own shortcomings.

I wish the County Secretaries would notify me when they are to have meetings. Let's Go!

Oscar F. Larson, M. D.,
President, Maine Medical Association.

Maine Medical Association Officers Elected at the House of Delegates Meeting

Augusta, Maine, June 20, 1943

President-Elect

Raymond Van Ness Bliss, M. D., of Blue Hill, Maine, was elected President-elect of the Maine Medical Association, at the meeting of the House of Delegates at the Augusta House, Augusta, Maine, Sunday, June 20, 1943. Doctor Bliss was born in Northern Vermont, educated at the University of Vermont and Jefferson Medical College. Formerly Capt., M. C., U. S. A., in World War I, Chief of the Orthopedic Surgical Service in base hospital, Camp Hancock, Georgia, and Chief of the Surgical Service in General Hospital, No. 31, Carlisle, Pa. Founder and surgeon to the Blue Hill Memorial Hospital since 1921.

Doctor Bliss has always been very much interested in the welfare of the Association and served three years as Councilor for the Fifth District.

Raymond Van Ness Bliss, M. D.

Forrest B. Ames, M. D.

Councilors

Fifth District

(Hancock and Washington Counties)

HAROLD S. BABCOCK, M. D.,
Castine, 1946

Sixth District

(Aroostook, Penobscot and Piscataquis Counties)

FORREST B. AMES, M. D.,
Bangor, 1946

Editorial

Highlights of the House of Delegates' Meeting June 20, 1943

The proceedings of the First and Second Meetings of the House of Delegates of the Maine Medical Association, held Sunday, June 20, 1943, at Augusta, will be published in a later issue of the JOURNAL, but for those who could not be present this brief resumé of the highlights has been prepared. It was a successful meeting, not only from the standpoint of attendance but also from the standpoint of interest shown by those present.

The First Meeting of the House assembled at 11.00 A. M., with a representative body in attendance. The appointment of a Reference Committee consisting of three delegates, and a Nominating Committee consisting of six delegates, was followed by the Council Report of 1942-1943 presented by the Council Chairman, Oscar F. Larson, M. D. Then came the presentation of the 1943-1944 Budget, totalling $7,200.00, as approved by the Council for the consideration and action of the members of the House. The budget as presented was approved by the House, and the annual dues for each member of the Association were increased from $8.00 to $12.00 in order that the budget could be met without drawing too heavily on Association savings, and in order that the work of the Association might be carried on, not only for our members on the home front but also in order that our members in the armed forces can come back to an Association prepared to meet the demands of a post war world.

The report of Thomas A. Foster, M. D., of Portland, delegate to the annual session of the House of Delegates of the American Medical Association, was heard with interest and will be published with the proceedings.

The Second Meeting of the House assembled at 4.00 P. M.

The report of the Nominating Committee, as published elsewhere in this issue, was presented by the Chairman, William Holt, M. D., of Portland, and approved by the House.

Oscar F. Larson, M. D., of Machias, was elected President for 1943-1944, and R. V. N. Bliss, M. D., of Blue Hill, President-elect.

Harold S. Babcock, M. D., of Castine, was elected Councilor for the Fifth District, and Forrest B. Ames, M. D., of Bangor, Councilor for the Sixth District.

All men well able to carry on the duties to which they have been assigned.

Many matters of current interest were discussed at length, at both meetings, proof that the members of this Association are wide awake to the many problems confronting the medical profession in this time of war.

Carl H. Stevens, M. D., of Belfast, retiring President, who presided at the luncheon meeting, has covered the business of that meeting in his Presidential Address. I do, however, want to mention the attendance, which included many members who were not delegates and their wives, and which was indeed gratifying.

The Council of the Maine Medical Association met for an organization meeting immediately following the Second Meeting of the House of Delegates. John O. Piper, M. D., of Waterville, was elected Council Chairman for 1943-1944. Frederick R. Carter, M. D., was elected Secretary-Treasurer of the Association, Editor and Business Manager of the Association's JOURNAL, and Esther M. Kennard was elected Assistant Secretary of the Association, and Assistant Business Manager of the JOURNAL. The 1944 annual session was discussed and the Secretary was instructed to send a questionnaire to every member of the Association requesting an opinion relative to holding the regular two-day session of the Maine Medical Association in 1944. (These questionnaires wese mailed from the Association's office on June 24th. If you have not returned yours please do so at once in order that the Council will know what action to take at its next meeting.)

These are the highlights, watch future issues of your JOURNAL for the verbatim report of this war-time meeting of the Maine Medical Association.

Nominating Committee Report

The report of the Nominating Committee as presented and accepted at the Second Meeting of the House of Delegates of the Maine Medical Association at the Augusta House, Augusta, Maine, June 20, 1943.

Nominating Committee

William Holt, M. D., Portland, Chairman.
George L. Pratt, M. D., Farmington.
C. Harold Jameson, M. D., Rockland.
Foster C. Small, M. D., Belfast.
Willard H. Bunker, M. D., Calais.
Leroy H. Smith, M. D., Winterport.

Standing Committees

Scientific Committee

Eugene E. O'Donnell, M. D., Portland, Chairman.
Forrest B. Ames, M. D., Bangor.
Roland L. McKay, M. D., Augusta.
Harvey C. Bundy, M. D., Milo.

Committee on Medical Education and Hospitals

Adam P. Leighton, M. D., Portland, Chairman.
Allan Craig, M. D., Bangor.

Medical Advisory Committee

Carl M. Robinson, M. D., Portland, Chairman.
Allan Woodcock, M. D., Bangor.
Frank A. Smith, M. D., Westbrook.
Willard H. Bunker, M. D., Calais.
C. Harold Jameson, M. D., Rockland.
Frank H. Jackson, M. D., Houlton.
Forrest B. Ames, M. D., Bangor.
The Secretary, ex-officio.

Legislative Committee

The President, ex-officio.
The President-elect, ex-officio.
Frederick R. Carter, M. D., Portland, Chairman.

Public Relations Committee

R. V. N. Bliss, M. D., Bluehill, Chairman.
Frederick T. Hill, M. D., Waterville.
Henry C. Knowlton, M. D., Bangor.
Harold E. Small, M. D., Augusta.
Roland L. McKay, M. D., Augusta.

Cancer Committee

Magnus Ridlon, M. D., Bangor (one year).
William Holt, M. D., Portland (two years).
Arthur H. McQuillan, M. D., Waterville (three years).
Julius Gottlieb, M. D., Lewiston (four years).
Mortimer Warren, M. D., Portland (five years), Chairman.

Committee on Social Hygiene

Oscar R. Johnson, M. D., Portland, Chairman.
Carl E. Blaisdell, M. D., Bangor.
Roscoe L. Mitchell, M. D., Augusta.

Publicity Committee

Frederick R. Carter, M. D., Portland, Chairman.
Oscar F. Larson, M. D., Machias.

Financial Advisory Committee

George L. Pratt, M. D., Farmington (1944), Chairman.
Foster C. Small, M. D., Belfast (1945).
Warren E. Kershner, M. D., Bath (1946).

Special Committees

As appointed by the President, Oscar F. Larson, M. D., Machias, in accordance with the By-Laws, Chapter V, Section 1.

Committee on Graduate Education

Frederick T. Hill, M. D., Waterville, Chairman.
Julius Gottlieb, M. D., Lewiston.
E. Eugene Holt, M. D., Portland.
Frank H. Jackson, M. D., Houlton.
LeRoy H. Smith, M. D., Winterport.
James Carswell, M. D., Camden.
Thomas A. Foster, M. D., Portland.

Tuberculosis Committee

Walter R. Gumprecht, M. D., Bangor, Chairman.
Loren F. Carter, M. D., Presque Isle.
Charles D. Cromwell, M. D., Fairfield.
Lester A. Adams, M. D., Hebron.
George E. Young, M. D., Skowhegan.
James W. Laughlin, M. D., Newcastle.
Francis J. Welch, M. D., Portland.
Herbert S. Everett, M. D., St. Stephen, N. B.

Committee on Maternal and Child Welfare

Albert W. Fellows, M. D., Bangor, Chairman.
Clair S. Bauman, M. D., Waterville.
LeRoy C. Gross, M. D., Auburn.
Alice A. S. Whittier, M. D., Portland.
Virginia C. Hamilton, M. D., Bath.
Guy E. Dore, M. D., Guilford.
Thomas A. Foster, M. D., Portland.

Committee to Survey Hospital and Medical Care

S. Judd Beach, M. D., Portland, Chairman.
J. Calvin Oram, M. D., South Portland, Secretary.
Edward M. Cook, M. D., York Harbor (First District).
George L. Pratt, M. D., Farmington (Second District).
Warren E. Kershner, M. D., Bath (Third District).
Edward H. Risley, M. D., Waterville (Fourth District).
Willard H. Bunker, M. D., Calais (Fifth District).
Storer W. Boone, M. D., Presque Isle (Sixth District).
Roscoe L. Mitchell, M. D., Augusta (Department of Health and Welfare).

Committee to Investigate Collection Agencies

Adam P. Leighton, M. D., Portland.

Committee on Industrial Health

Joseph B. Drummond, M. D., Portland, Chairman.
Edwin M. Fuller, M. D., Bath.
Eugene M. McCarty, M. D., Rumford.
Arthur H. McQuillan, M. D., Waterville.
Allan Woodcock, M. D., Bangor.
Roscoe L. Mitchell, M. D., Augusta.

Committee for Conservation of Vision

Warren E. Kershner, M. D., Bath, Chairman.
Howard F. Hill, M. D., Waterville.
S. Judd Beach, M. D., Portland.
E. Eugene Holt, M. D., Portland.
Walter J. Gilbert, M. D., Calais.

Amy W. Pinkham Fund Committee

Thomas A. Foster, M. D., Portland, Chairman.
Virginia C. Hamilton, M. D., Bath.
Guy E. Dore, M. D., Guilford.
Albert M. Carde, M. D., Milo.
Clair S. Bauman, M. D., Waterville.
P. L. B. Ebbett, M. D., Houlton.
John F. Hanson, M. D., Machias.

Maternal and Child Welfare

Indigestion in Infancy

This discussion will not include pyloric stenosis, serious digestive disorders, or indigestion dependent on infections, but the physician should watch for diseased adenoids, otitis, pyelitis, tuberculosis, and syphilis.

A good feeding history is essential and usually leads straight to identification of the offending element. Ascertain the changes brought about by each change of formula, and do not forget to enquire what breed of cattle the milk comes from. Jersey, Guernsey, and some mixed herds yield a milk high in fat content. It is of no use to try to correct indigestion in infancy by supplying digestive ferments, as there is no lack of these. It is well to have in mind the types of indigestion produced by excess of the various food elements so that one will avoid blindly trying one thing after another, often without making any essential change. This excess may be absolute or relative to the infant's capacity.

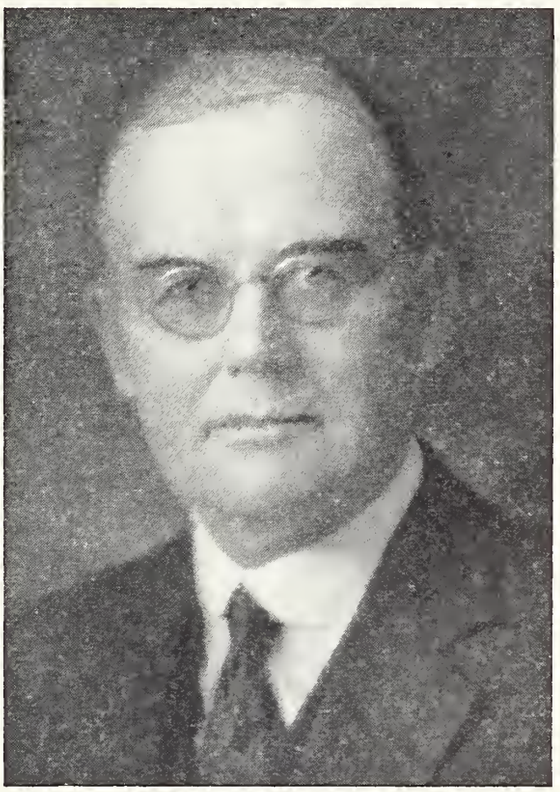
Overfeeding as a whole is easily discovered by taking a history. The baby usually spits more than just spilling over, passes undigested stools, and often has colic. A sort of intermittent anorexia is usually present. The baby goes for his bottle eagerly but is satisfied before finishing and falls asleep, only to wake before the next feeding is due. A simple reduction in strength of the formula is all that is necessary. Cut it to the point where he takes eagerly the calculated twenty-four hour amount (3 oz. per pound of body weight) and explain to the mother that the primary object is increase in appetite. Weight gain will come later. Increases in the formula are made gradually.

Indigestion from excess of fat usually presents characteristic symptoms. Anorexia is a prominent feature. The baby seems not to care whether he eats or not and, if left alone, will sometimes go an extraordinarily long time. The stools are of three types, the one resembling scrambled eggs, the hard, dry, gray or white one, or the more or less pasty stool containing numerous pin-head to split pea sized soft, white curds of undigested fat. Vomiting is common and characteristically occurs late in the feeding interval. The material vomited is watery and very sour. The treatment is to reduce the fat in the formula. In a severe case, make it from skimmed milk. Strangely enough, the baby will often gain weight. As appetite returns, and the other symptoms abate, add gravity cream to the formula an ounce at a time. Gravity cream is the cream that rises above the cream line in the dairy bottle, and contains sixteen per-cent of fat. Remove it all, mix it, and take the desired quantity. In less severe cases, it is usually sufficient to remove the top two or three ounces from the bottle before mixing the formula. Dextri-maltose seems to be the sugar of choice in these cases. The cod liver oil should be given in one of the concentrated forms. For practical purposes, the appetite may be considered a reliable guide for making increases, but in severe cases the laboratory must be consulted.

The main feature of carbohydrate indigestion is diarrhœa, often accompanied by gas and colic. The stools are loose or spongy, the latter appearance due to contained gas bubbles, the result of fermentation. The buttocks are usually excoriated because the stools are acid. Vomiting is usually not a prominent symptom and bears no constant relation to feeding time. In fermental diarrhœa the bacteria of the intestinal tract are predominantly sugar splitters. The object of treatment is to starve out these bacteria. If the formula contains a large amount of carbohydrate, simple reduction of this element and a change of type may be all that is necessary. For example, milk sugar may be changed to dextri-maltose in reduced amounts. The dextri-maltose preparations are better than simple sugars in this condition because there is less fermentable material in the intestine at any one time. In severe cases, reduce radically or omit the added carbohydrate, and increase the protein, on which the fermental

Continued on page 146

Necrologies



Everett B. Currier, M. D.,
1866-1943

Everett B. Currier died suddenly on May 22, 1943, of heart disease, in St. Petersburg, Florida.

He was born in Wilton, Maine, April 12, 1866, the son of Betsy Keith and Russell Sweet Currier.

Doctor Currier graduated from Wilton Academy in 1884, from Westbrook Seminary in 1888, and from the College of Physicians and Surgeons, Baltimore, in 1893. He also attended the Maine Medical School.

In May, 1893, he began the practice of medicine in Rangeley, Maine. The next year he moved to Phillips, Maine, where he practiced until his death, except during the winter months of the past fifteen years which were spent in St. Petersburg.

On May 9, 1895, he was united in marriage with Georgia Evelyn Bigelow of Rangeley, who survives him.

He was a member of the Franklin County Medical Society, the Maine Medical Association, and the American Medical Association. Also of Blue Mt. Lodge, F. & A. M., Saddleback Lodge, No. 92, I. O. O. F., and Hope Rebekah Lodge.

He was to receive this year the Fifty-Year Gold Medal of the Maine Medical Association.

Doctor Currier was an able and honorable practitioner of medicine who will be missed and long remembered by his colleagues and a host of patients and friends.

G. L. P.

Robert Titus Phillips, M. D.,
1901-1943

Robert Titus Phillips, Major, M. C., who was captured by the Japanese after the fall of Bataan, died in a Japanese prison camp June 11, 1943, according to word received by his twin brother, Lieut. Comdr. Richard B. Phillips, U. S. Navy Medical Corps, Norfolk, Va.

Doctor Phillips was born in Boston, Massachusetts, September 15, 1901, a son of Alexander Van Cleve and Anna Mills Phillips. He was graduated from Bowdoin College in 1924 and from Tufts Medical School in 1932.

He located in Portland in 1938, where he remained until January 1941 when he entered the Army Medical Corps.

He was a member of the Cumberland County Medical Society, the Maine Medical Association, the American Medical Association, and the American Rheumatism Association. He was also a diplomate of the National Board of Medical Examiners.

He is survived by his widow, Mrs. Elizabeth Kittredge Phillips, and four children, all of Milford, N. H., his father and mother, and six brothers and sisters.

COUNTY SOCIETIES

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President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Thomas G. Harvey, M. D., Mars Hill
Secretary, Clyde I. Swett, M. D., Island Falls

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Penobscot
President, Ernest T. Young, M. D., Millinocket
Secretary, Forrest B. Ames, M. D., Bangor

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President, Albert M. Carde, M. D., Milo
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York
President, Arthur J. Stimpson, M. D., Kennebunk
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Cumberland

The Cumberland County Medical Society met at the Maine General Hospital on May 21st. The meeting was preceded by an afternoon clinic at the hospital and followed by a buffet lunch.

Ernest B. Folsom, M. D., of Portland and Waldo T. Skillin, M. D., of South Portland were reinstated to membership.

The speaker of the evening was Joseph McCloskey, M. D., the United States Public Health Service, whose subject was the "Clinical Aspects of Venereal Disease." Dr. McCloskey's talk was illustrated by lantern slides. Judge Robert DeWolfe, Drs. Benjamin B. Foster, O. R. Johnson, O. E. Haney, N. B. T. Barker, and Adrain Scolten participated in the discussion which followed.

The meeting was adjourned at 10.15 p. m.

EUGENE E. O'DONNELL, M. D.,
Secretary.

Penobscot

The regular monthly meeting of the Penobscot County Medical Association was held at the Bangor House, Bangor, Maine, on Tuesday, May 18, 1943.

Dinner at 6.30 P. M., was followed by the business meeting and Scientific Session.

Charles H. Lawrence, M. D., Professor of Clinical Medicine, Tufts Medical School, was the speaker of the evening. His subject was *The Significance of Sex Hormones in Clinical Medicine and Surgery.*

FORREST B. AMES, M. D.,
Secretary.

Piscataquis

A meeting of the Piscataquis County Medical Association was held at the Blethen House, Dover-Foxcroft, Maine, Wednesday evening, May 19, 1943. Dinner was served at 6.30 P. M., after which the regular meeting was called to order by President A. M. Carde, M. D. Minutes of the last meeting were read and approved.

The speaker of the evening was Martin Vickers, M. D., of Bangor, Maine, whose subject was "Allergy." This was followed by a round table discussion.

This was a very interesting meeting as attested by the fact that the discussion continued until 10.45 P. M.

HARVEY C. BUNDY, M. D.,
Secretary.

New Member

Oxford

George F. Shurtleff, M. D., Andover, Maine.

Notices

Maine Medico-Legal Society

The annual meeting of the Maine Medico-Legal Society was held at the Augusta House, Augusta, June 20, 1943, President Albert Knudsen of Portland presiding.

The reports of the Secretary and Treasurer were read and accepted.

A letter from Governor Sewall was read, regretting his inability to be present.

Lawrence Upton, Acting Chief of the State Police, Captain Joseph Young and Lt. Merle Cole, also of the State Police, were elected to honorary membership, also Assistant County Attorney Fellows of Penobscot County

All new Medical Examiners and County Attorneys were elected regular members.

The Executive Committee was authorized to act for the Society during the ensuing year.

Former Attorney General, Franz U. Burkett, intruduced the question of "How Far Should the State Go in Taking over from the Counties in Homicide Cases."

The question was thoroughly discussed by the Attorney General, several County Attorneys, Medical Examiners, Pathologists and Police Officers.

The general feeing was that best results would come from better coöperation of all existing agencies.

Dr. W. W. Watters of Boston, Medical Examiner of Suffolk County, commented on the discussion, and announced a course of instruction in October, in Boston, to which all Medical Examiners, Pathologists, County Attorneys and Police Officers are invited.

Medical Examiners and County Attorneys not present should send the annual dues of $1.00 to W. S. Stinchfield, M. D., Skowhegan, Treasurer.

Officers for the ensuing year were elected as follows:

President—D. M. Stewart, M. D., South Paris.

Vice President—Benjamin Butler, County Attorney, Farmington.

Secretary—George L. Pratt, M. D., Farmington.

Treasurer—Walter S. Stinchfield, M. D., Skowhegan.

G. L. Pratt, M. D.,
Secretary.

Medical Replacement Training Center Camp Barkeley, Texas

Beginning with the class which reports for training on July 9, the Medical Administrative Corps Officer Candidate School is lengthening its training period to 16 weeks, four more than the present program calls for.

In announcing this scheduled compliance with a War Department directive, Major Miles G. Bell, MAC, school executive officer, also said, "The new schedules will involve no addition of material, it will merely mean a more intensive coverage and study of the work now included." All the departments of the school—training, chemical warfare, administration, legistics, tactics, and sanitation—will be allotted some of the extra hours added to the training program.

The present field work will be especially affected by the new schedules which have been submitted to the War Department training division. A continuous problem in medical support will be carried out during a six-day bivouac, for each Camp Barkeley class and the candidates will practice choosing aid station sites, evacuation routes, and other medical installations in simulated battle conditions.

The strength of the school, 12 companies, will remain the same, with the result that the output will be slightly decreased. It is felt that this decrease will be more than compensated by the invaluable extra time spent upon the subjects in the curriculum.

Over 6,000 men have already received commissions as second lieutenants in the Medical Administrative Corps from the Camp Barkeley school, in addition to those who completed their training at Carlisle Barracks, Pa., before the MAC school there closed this spring. The non-medical functions of this youngest of the army Medical Department's officer corps have proved invaluable in many fields.

The American Congress of Physical Therapy

The American Congress of Physical Therapy will hold its twenty-second annual scientific and clinical session September 8, 9, 10 and 11, 1943, inclusive, at the Palmer House, Chicago. For information concerning the instruction course and program of the convention proper, address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, Illinois.

American Board of Obstetrics and Gynecology, Inc., Examinations

Applications for the 1944 examinations of the Board are being received at the office of the Secretary, Dr. Paul Titus, 1015 Highland Building, Pittsburg, Pennsylvania. Booklets of information regarding Board requirements and examinations, together with application forms will be sent upon request.

All applications for the year 1944 must be in the Secretary's Office not later than November 15, 1943, ninety days in advance of the Part I examination date.

Candidates are required to take both the Part I and Part II examinations. The Part I examination consists of the written paper and the submission of twenty-five case history abstracts, and will be conducted on Saturday, February 12, 1944. This examination will be arranged so that the candidate may take it at or near his place of residence. Upon the successful completion of the Part I examination, candidates are eligible for the Part II examination consisting of a pathology and an oral examination. This is given at the annual meeting of the Board once each year, the time and place of which will be announced later.

The Office of the Surgeon General (U. S. Army) has issued instructions that men in Service, eligible for Board examinations be encouraged to apply and that they request orders to "detached duty" for the purpose of taking the examinations whenever possible.

Correspondence

June 9, 1943.

Frederick R. Carter, M. D.,
Secretary-Treasurer, Maine Medical Association,
High Street, Portland, Maine.

Dear Doctor Carter:

Re: Chapter 251, Public Laws 1943 — An Act
Relating to Pre-marital Medical Examination.

In my report to you on 1943 legislation published in the Journal for May, 1943, Pages 96 and 99, there is an error.

First, the waiver may be granted (beginning July 9, 1943) by a *Judge of Probate* as well as by a Superior Court Judge. This statement in my report is correct.

Second, it is not true as stated in my report, Item 7, Page 96, that "any doctor of the Armed Forces or any laboratory of the Armed Forces or state laboratories of other states" may furnish acceptable reports for pre-marital exam. This provision and some others were in the bill as originally proposed. As finally enacted, this provision and those others were omitted.

Regret this error. In my attempt to get to you a report within two or three days after Legislature adjourned, I failed to cut out this provision.

Yours truly,

Herbert E. Locke,
Attorney.

HEL/mt

Maternal and Child Welfare—Continued from page 142

bacteria cannot live. The latter can be done by adding one-third of an ounce, or even more, of casec to the quart of formula. As relative constipation replaces diarrhœa, increase the carbohydrate, and later reduce the casec.

Protein indigestion in the stomach causes vomiting of large curds. In the bowel it results in the passage of slushy, foul-smelling stools which are alkaline, or more commonly in stools containing bean-sized protein curds which are tough and rubbery. This condition is rarely particularly troublesome. Methods of making the protein more digestible were mentioned in the June article.

Never change the formula of a thriving baby for minor symptoms. When you do make a change, know why you are doing it, and give it time to take effect before making another.

Your Committee on Maternal and Child Welfare.

The Journal
of the
Maine Medical Association

Volume Thirty-four Portland, Maine, August, 1943 No. 8

*Emergency Medical Service**

By A. William Reggio, Sr. Surg. (R.) U. S. P. H. S., Regional Medical Officer,
First Civilian Defense Area

President Stevens, Dr. Moulton, Members of the Maine Medical Association, and Ladies and Gentlemen. It may be of some interest to you to hear how this Office of Civilian Defense works. We confine ourselves chiefly, of course, to the medical part of it.

On the 20th of May, this year, the Office of Civilian Defense celebrated its second birthday. In other words, the Office of Civilian Defense is a little over two years old now.

Regarding the Medical Service, it starts in Washington, with Dr. George Baehr, who is in charge of all the medical Civilian Defense. Then through him, the medical part of it is administered by the Regional Medical Officers, in nine regions, which correspond to the nine Service Commands.

We, here, are in Region 1; that is, the six New England States comprise Region 1. Our office is in Boston, at 17 Court Street.

The Office of Civilian Defense Medical Service starts with Dr. George Baehr; then it goes to the Regional Medical Officer. Working with the regional medical officer is the State Chief of Emergency Medical Service. He is the next one, and of course, he and his Deputy and the State Hospital Officer are the three functioning men in the State. Then it comes down, after that, to the local chief medical officer, who has the real headache and the real work to do in what he has to attend to when he sets up the service in his locality.

The State Chief of Emergency Medical Service also has with him a State Nurse Deputy, and, counselling with him also is the state hospital officer, the mortuary service, and a state medical gas officer, because we are still conscious of the fact that although the enemy has not yet struck on our shores, we are not so blind as to think that the enemy will not do so. We are convinced they will; we cannot imagine that they won't. They still have an idea that they can break our morale by a bombing from the air, and of course they don't realize that that is the one thing we need to pull us together and get us really mad. We aren't really mad yet. We *are* vulnerable. The enemy would like nothing better than to start crippling us the way

* Presented at the Luncheon Meeting of the Maine Medical Association, House of Delegates, Sunday, June 20, 1943, Augusta, Maine.

we are crippling them. So we have got to be ready, and the welfare of the civilians rests in the hands of the medical men in the Civilian Defense, chiefly with the local Chief Medical Officer, who is responsible for his community.

He is a busy fellow. He has a lot of things to do. He has to see to it that mobile medical teams or medical units are established. He has to see to the casualty stations; he has to see that they are established, so that these mobile medical units can function and can go out from there, because the casualty stations are not all in the hospitals. Some hospitals have casualty stations, and some do not. But he has to see to it that the casualty receiving hospital, as we call it, which is nothing more or less than our every-day civilian hospital, slightly reorganized and set up, is ready to function on an emergency basis when the occasion arises.

He also has to see to the transportation of the units and of the injured, by ambulances, converted station wagons, delivery trucks and such.

Then he has to see to the tie-up with the Red Cross in the local community, because he may need a canteen, and he may need first-aiders and Red Cross workers to help.

He also has a partial responsibility on the medical end of the civilian evacuation of the uninjured, because when the older people and children have to be evacuated, possibly through enemy action or through Army orders, they will have to have medical attention. An epidemic of scarlet fever or measles or something might start with the children, and the older people might have heart attacks, so they must have a medical man there. And so he ties in with that.

He has a pretty big job on his hands, that is all helped and directed through the State Chief, and then back through the Regional Medical Office. It is a large responsibility, and the way the men have been doing this has been most encouraging. There have been no gripes. Every single medical man approached has knuckled right down and taken it on in addition to all the terrific amount of work he is already doing. And, of course, the salary that goes with it is tremendous! But he has done it willingly and gladly.

It may interest you to know what we have in the Region. We have about 950 mobile medical teams; that is, in the six New England states. About 430 casualty stations, exclusive of the hospital ones, and about 300 casualty receiving hospitals, and 15 emergency base hospitals.

The emergency base hospitals are large institutions; if possible, they are state institutions, which have been surveyed and looked over by the State Chief and the State Hospital Officer and the Regional Medical Officer, and arrangements have been made with the State to take care of evacuated patients from the casualty receiving hospitals, if it becomes necessary. We have 32,000 acute casualty beds, in the Region, and 8,000 emergency base hospital beds. That is on a ratio of one emergency base hospital bed for every four casualty receiving hospital beds. That has all been worked out, and plans have been laid for evacuating hospitals, if necessary. Those people who are evacuated to the emergency base hospitals have to be looked after, and for that reason, there have been formed in the Region 27 affiliated base hospital units. Those affiliated units are recruited from the older medical men, and some of these units are sponsored by medical schools and hospitals.

There are fifteen men to an affiliated unit; there are six surgical men, four medical men, a pathologist, an x-ray man, two orthopedic, a dentist, and the men on those units hold inactive reserve commissions in the United States Public Health Service. If such a unit has to be activated, the State Chief of the Emergency Medical Service will activate such a unit. He will decide which unit goes where. Then he confers with the unit leader and that unit is mobilized, and just as soon as it is activated, then automatically these men who are on the inactive reserve go into active status and are paid by the United States Public Health Service, according to their rank, for as long as they are on duty. We have no idea how long a time that would be; it may be a week or two, or it may be a month.

There has been a good deal of quandary in the minds of the men who have been asked to join these units, because the papers are rather

formidable, as those of you who have seen them will readily admit, and a casual perusal of the papers will make you think that you are signing your life away and you don't know whether you are going to land in Alaska, South America or where, although I have seen some men who were afraid they wouldn't be sent away somewhere. Well, they won't be sent away. They will be as close to their home base as possible. That is an agreement with the Public Health Service.

We also have what are called grantee hospitals. These grantee hospitals are 26 in number, and they have received funds from the Public Health Service for the processing and storing of blood plasma. There are 16 more plasma bank hospitals which store plasma. That plasma is necessary, as you perfectly well know. We couldn't get along without it. At the present time, we have over 25,000 units stored in our hospitals in this Region. The banks are becoming filled rapidly.

We speak of this blood plasma as the Office of Civilian Defense plasma, and it is to be used; it is not to be kept there idle, if there is any question at all about any patient needing plasma, that plasma is available and ready for use for any patient under any conditions whatever. There is just one provision, and that is, the amount used is replaced as soon as possible by one or two more donors being furnished. We want to keep those banks living banks. We want to use the plasma. We want to get the men accustomed to using plasma and in that way to find out its value. They can call for it any time, with the provision that it be replaced as soon as possible after it has been used.

If some community gets into trouble and needs plasma, we have an arrangement with the Civil Air Patrol to fly plasma there, if necessary. At other times, we have arrangements with the State Police to pick it up and make it available. And this plasma is available. I want to emphasize that. At the Office of Civilian Defense, we have another 850 units of dried plasma, which we can fly any place at a moment's notice. It is ready for use any time.

Another thing which has created a good deal of interest is the question of whether we are going to have gas used against us or not. We don't know. Nitrogen-mustard gas does a beautiful job on the eyes, so we must be ready for it. Indeed, it would be foolish not to be ready for it. On the other hand, we must not go into any large expenditures for cleansing stations. We speak of them as cleansing stations, as they are the ones which will de-contaminate the individual, and the de-contamination station is the place where objects, materials, trucks, clothing and what-not will be de-contaminated. So we call them cleansing stations.

We are very anxious that every hospital makes some provision for setting up a cleansing station. There should be no special expenditure planned. Existing facilities should be adapted for that purpose. In the hospitals, for example, there are the autopsy room, hydrotherapy rooms, shower baths and places like that, where water is available. It is a relatively simple thing to convert what existing rooms there are into a cleansing station.

I have been around to a great many of the hospitals and most of them can readily adapt some part of their hospital to this cleansing station use. If it cannot be done in the hospital, a nearby school where they have shower facilities or a gasoline station that has a large building for washing cars will do. You cannot bring contaminated patients into a hospital, because it will contaminate the rest of the hospital. Therefore, the cleansing station program is important, because if the enemy should use gas and we haven't got the cleansing stations to take care of the cases, we would be in an awful jam.

As you know, gas is a panic producer; that is the main idea of the whole thing; to produce panic. War gas is not as terrible a lethal weapon as it is supposed to be. The public still thinks so, but the public must be educated to the fact that it is not so.

The object of a vesicant gas is to burn the skin. It takes a relatively short time to burn the skin, ten or fifteen minutes with some of the gases. If you have a big cleansing station set up for uninjured civilians, you are going to have them lining up outside, and by the time the last fellow gets in, many of them will be nicely burned; the damage will be done, and they will have no use for the cleansing sta-

tion, because it is too late. So, whatever measures are going to be taken towards decontaminating or cleansing from this war gas, they must be taken immediately. Time is the big element. You cannot delay. Five to seven minutes of nitrogen mustard in the eye, if you are directly hit with it, will do the damage, and you can't be waiting half or three-quarters of an hour outside a public cleansing station to have it attended to. Therefore, the public has to be educated to take care of themselves with a sort of first-aid, self-aid program against war gas. It can be done. It is being worked out now. The film you are going to see this afternoon is a film which is being made in 35-millimeter size to be shown in the different moving picture houses.

A person can look out for himself much more readily than any large public cleansing station can.

The vesicants, as you probably know, are the chief ones that may be used; mustard gas, from the last war, lewisite, and now the nitrogen-mustard gas.

Nitrogen-mustard gas is about five times as slow acting on the skin, and with half the amount of reaction on the skin that mustard gas will give, but it is ten times as quick and serious in the eye; that is where the danger is going to come. There is the danger of direct little droplets hitting the eyeball.

The gas mask is complete protection against all war gases, except the vesicants, and of course, except carbon monoxide.

The vesicants will not only bother the eye, but will also bother the respiratory tract, if in large enough concentration. Your gas mask protects against this, but not against the vesicant action. The lung irritants, chief of which is phosgene, sneak up on you, and you won't know about the irritation for a number of hours.

Other gases cause vomiting and the tears to run. Another, adamsite, is one of the smoke gases, and when people get that into their noses, it gets into the sinuses, causing headache, and they are almost crazed by the pain and want to commit suicide; but then, they calm down and in about an hour or so they are all over it. Another one, of course, is phosphorous, and the phosphorous burns. You know perfectly well that when phosphorous bursts into flame, it goes merrily on because of the contact with air. Another nice feature of it is that it will burn right on merrily, too, when it comes in contact with tannic acid. That is the chief reason why tannic acid and tannic acid water soluble ointments have been taken out of the first-aid kits for burns, because they found in England from the new explosive bombs where there was phosphorous, if they put on tannic acid jelly it made the phosphorous burn a little bit more merrily.

Another thing on this chemical warfare is that we hope very much that the doctors in this state will pay pretty close attention to the chemical warfare gases. We suggest, for example, that perhaps at some of your local district meetings, you will devote some of your time to the discussion of the war gases; have somebody come to speak about them, and in that way you will have some idea of what to do, because the treatment is relatively simple, and the recognition of them is entirely outside the medical sphere.

The State Chemical War Gas Officer is the man who will identify the gas. We don't care what the gas is, medically, we are going to treat them all alike, because we haven't time to find out, before we get to work on them, just what kind of gas it is. It takes too long to find out the kind of gas used, and you can't go by the smell. When bombs go off and fires are burning; sewers and gas mains are interrupted, you can't smell the war gas. So the simple remedy, or first-aid measures against gas, must be known.

So, the State Medical Gas Officer should be in very close touch with the Chemical Gas Officer, and work out plans for informing the public regarding the cleansing stations and the hospitals, and bringing very strongly before the public what they must do for themselves, just as this film is going to show you.

There is just one more thing that Dr. Moulton has suggested I mention for a moment, and that is what is known as the War Civilian Security Program. That is a program which provides for payments and benefits to injured civilian defense workers, the Civil Air Patrol and the Aircraft Warning

Continued on page 153

*Dementia Praecox**

By Forrest C. Tyson, M. D., Superintendent, Augusta State Hospital, Augusta, Maine

In the schizophrenic psychoses which are commonly grouped under the heading Dementia Praecox, we find a form of personality disorder characterized by an insidious onset, beginning in early adolescence, and marked by a strong tendency toward gradual mental deterioration.

They constitute about 25% of all psychoses. Males are slightly more susceptible than females. Onset of symptoms any time after the adolescence period, mostly at 18 years to as high as 35 years. They constitute about 50% of patients in State Hospitals because of their chronicity.

As the illness begins early in life and before there is much opportunity for reproduction, heredity appears to be unimportant.

While certain organic changes have been described in the brain, none has been found consistently or generally accepted as having anything to do with the illness. It is probable that psychological changes accompanying the maturation of the sex function during adolescence have important causal relationships.

The adolescence period is a difficult one sometimes for most individuals but those who have schizophrenic tendencies have in addition incompatible personality traits—as, lack of self confidence, shyness, sensitiveness, self consciousness, prudishness. And on the other hand, they may be proud, ambitious, determined and driven by strong sexual cravings. Their pride is easily and often constantly wounded, gratification of their desires and ambitions is frustrated by their shyness and lack of aggressiveness. An unhealthy attitude toward the opposite sex makes it difficult for them to manage strong sexual cravings naturally.

They are often determined to succeed, this increases the conflict between the urges of the personality. As the internal conflict increases, they find it difficult to make the proper adjustments to the environment and an intolerable situation results. They begin to lose interest and begin a retreat from the harsh world of reality, and succumb to a world of fancy—where one may dwell in self indulgence. The change manifests itself by secretiveness, seclusiveness, mistrust and even indifference. As contact with the real world diminishes, the patient becomes more and more preoccupied with his own world of fancies. This is the easiest way out of an embarrassing situation, because the patient can make use of the earlier and more familiar modes of adaptation, childhood adaptations in a sense. He enjoys once more the experiences of childhood — eroticism, homosexuality, etc. This is accomplished by regression. The patient becomes fascinated by this dream world and does not wish to be disturbed — introverted — shut in or schizoid personality.

In this disorder early homosexual tendencies, normal at that time, are carried over into the post adolescent period and give rise to intense conflict within the personality through failure to obtain some outlet in frank expression. Such a person is likely to become schizoid and to develop paranoid and schophrenic psychosis that we classify as Dementia Praecox.

About half the population is inclined to present a predominance of schizoid traits. People who are inclined to be governed by their own trends of thought and feeling, even though this clashes with others. The more schizoid one becomes the less able one is to adjust to the real world. Just when the patient becomes schizophrenic may be arbitrary but it is marked by a noticable withdrawal of interest from the external and a frank expression of selfish desires which are ordinarily kept repressed in the unconscious in ordinary persons.

Withdrawal is never complete, some lingering evidence of reality and a painful awareness of a futile struggle to maintain contact with reality persists.

* Read at the annual meeting of the Kennebec County Medical Association at Augusta, December 10, 1942.

In Dementia Praecox — Schizophrenic process — the psychosis is a compromise at the expense of disorganization of the personality. Preoccupation with strange bodily sensations, worry over incestuous thoughts, masturbation, passive relation with opposite sex. Preoccupations interfere with one's usual social and emotional relationship. They become introspective and withdrawn. Free thought is blocked by painful associations. Dissociation — disconnected thoughts may appear as something quite foreign and not be recognized as belonging to the patient — autistic thinking. As the illness progresses, the clinical manifestations change. Catatonic symptoms appear and in the acute stage one can recognize an admixture of hebephrenic and paranoid symptoms.

Catatonia: Psychomotor functions, come quickly and disappear quickly. Excitements are bizarre and unpredictable.

Paranoid: Ideas of persecution. Delusions and hallucinations. Compensatory strivings against homosexual desires. Morbid mental anxiety over the delusion that some mysterious, hypnotic influence is being exerted to overcome the patient's resistance to perverted sexual activity.

Hebephrenic and simple forms:

Case 1

Admitted January 17, 1942, at the age of 22. Ship fitter. Graduated from high school at the age of 17. Was in a C. C. C. Camp. Worked two years in a paper mill and left to work in the South Portland ship yard. Was arrested and accused of assaulting a girl with whom he was going. Sentenced to 30 days in jail. While in jail was committed to the hospital by the Judge of Municipal Court.

History of sexual irregularities, police difficulties, wandering about. Considered a moral pervert. History of mental trouble in the family. He was over religious. Carried religious ideas to the extreme. Thought that he might be a minor Christ at one time. Heard voices. He said, "I am sitting here now talking to you but I have just heard a voice tell me if I went out on the street I would have a good revelation." The boy's father was peculiar, below grade mentally and wanders from one place to another. Mother more stable but not very intelligent. Family has always been troublesome. Is alleged to have smoked marihuana. Physically asthenic type.

Was complained of by father of girl. Placed in jail. Examined by a psychiatrist and pronounced a mental case and sent to the State Hospital.

Patient released on trial visit March 9, 1942. Subsequently was taken into the service and employed at the Bangor Airport. When his record was discovered, he was discharged from the service.

Diagnosis: Dementia Praecox.

Case 2

Admitted January 24, 1942, at the age of 26. Inducted into Military Service March 1, 1941. Was said to be a good student in school. Graduated from Fryeburg Academy in 1934 at the age of 19. Rather sensitive. Got along well with the boys, but was easily embarrassed by the opposite sex. Would not dance, but would go and listen to the music. Went to a C. C. C. Camp and was honorably discharged. Employed on road construction. Was upset over being inducted into the service. Had influenza.

After induction was sent to Fort Devens, Mass. Mother was notified November 5, 1941, that patient was in the Station Hospital at Fort Jackson, South Carolina. Arrangements were then made to transfer him to Maine. He was returned to Fryeburg and then committed to this hospital. Patient was restless and talked a lot about the army and Germans being down in Florida. Was quite disturbed. Parents had to stay up all night with him. Physically he showed some cataleptic rigidity.

Course in the hospital rather one of indifference, not particularly interested. No insight into his condition. A bit manneristic. Some catatonic negativistic tendencies.

Diagnosis: Dementia Praecox.

Case 3

Admitted February 7, 1942, at the age of 28. Inducted in the U. S. Army March 10, 1941. Temperamentally good natured. Rather bashful. Always went to church. Good worker but quick tempered. Preferred to keep by himself. Read little but liked music. Committed as an emergency case, after being returned from Camp Blanding, Florida. Case diagnosed as a case of Dementia Praecox. Was irritable, inclined to be violent, struck at those who came near him. Had to be forced into the car that was to bring him to the Augusta State Hospital. Struggled some on the way.

Patient here has been rather apathetic, indifferent, smiles to himself. Resistive to examination. Assaultive, untidy. Had to be confined to a room because of his assaultive tendencies. Refused to take food and was tube fed on one occasion. Subsequently had to be tube fed for two weeks. Catatonic, stuporous-like resistance. Laughs in a silly manner. Difficult to examine and is very uncooperative. After a few weeks he became more tractable and began to eat. Gained 30 or more pounds in weight.

Diagnosis: Dementia Praecox.

Case 4

Admitted August 9, 1942 from the Station Hospital at Pine Camp, N. Y., at the age of 22. Inducted into the army October, 1941. On August 11, 1942, he was discharged outright from this hospital in the care of his sisters.

Subsequently he was supposed to have shown some violence at home and was recommitted September 9, 1942. He completed the 8th grade. Had no regular employment. Worked on his father's farm and on town road work. Some time before induction into the service, he was referred to a neurologist for examination. Brain tumor suspected. Patient complained of numbness in left hand and soreness of his face after shaving. No pathological discoveries at that time.

In the service he attempted to qualify in the Parachute Division. Restless, wandering about the camp at night. Laughed loudly or cried. Seemed irresponsible, disobedient. Would not keep his rifle pointed down the range, once actually pointed his rifle at a noncommissioned officer. Sent to detention ward for observation. Inclined to be antagonistic and uncoöperative. Refused to have his temperature taken. Ate poorly and did no work about the ward. Rather dull and seclusive, did not associate with others.

Diagnosis: Dementia Praecox.

Emergency Medical Service—Continued from page 150

Service. That depends entirely upon the Personnel Officer, who must be appointed in each community, because this Personnel Officer has to keep a record of the enrolled personnel and any one who is injured.

For example, if you have an auxiliary fireman who is in training and he is called out by his fire chief to attend a fire and he becomes injured as a part of his training course, his hospital bill, his doctor's bill and/or medicines and/or treatment will be paid for by the United States Public Health Service, provided he is a trainee or has been duly enrolled in the United States Citizens' Defense Corps.

Here in Maine, this is a very simple procedure, because every civilian defense worker is registered and approved by the State and is given a numbered arm band. Therefore, those workers automatically would become members of the United States Citizens' Defense Corps. Only members of the defense corps are eligible to the benefits of the War Civilian Security Program. It all hinges on the personnel officer. To those of you who are the local Chief Medical Officers, I might suggest that it would be very wise if you found out who the local Personnel Officer is, and if there isn't one, just simply keep scrapping until you get one through your State Command, because it is an important program, and it is the only way that the civilian workers, if injured in practice sessions, will be taken care of financially.

(The film on Chemical Warfare was then shown.)

The President's Page

To the Members of the Maine Medical Association:

My message this month concerns Senate Bill 1161.

The governmental control of medicine will eventually eliminate free enterprise, destroy self-faith, dim clear vision, and shake the confidence of one of the countries greatest institutions, The American Medical Man.

Can you visualize a politically controlled physician? Can you see him answering the beck and call of the ward or counties political boss; with the result that those physicians most amenable to political moulding getting the plums whether deserved or not.

This is the surest way to lose the freedom for which our sons are fighting. Our own sons, our neighbors' sons, are suffering untold hardships, many maimed for life, killed even, in order that we and they may continue to live our lives in this American Way, as heretofore: let us not let them come home to a country which is still the home of the brave, but NOT the land of the free.

Senate Bill 1161, known as the "Wagner-Murray" bill, is the broad entering wedge with which those Bureaucratic theorists and Medical Eutopians hope to establish a beach-head in the very middle of the Medical Man's life line.

I wish and ask that every physician in the State of Maine carefully read the booklet, "Abolishing Private Medical Practice," which has been mailed them by the National Physicians Committee, afterward fill out the enclosed postal card and mail; this is vitally important to our future welfare.

Winston Churchill says, "We must beware of trying to build a society in which nobody counts for anything, except a politician or an official, a society where enterprise gains no reward and thrift no privileges."

Oscar F. Larson, M. D.,
President, Maine Medical Association.

Editorials

Council Votes in Favor of 1944 Annual Session

I know that all members of the Association are looking forward to the vote of the Council relative to the 1944 annual session of the Maine Medical Association. It is, therefore, a pleasure to devote this Editorial Page to a brief resume of the meeting of the Council at which it was voted to hold the regular two-day session in 1944; a vote which is the vote of the members of the Association as it was governed by the replies to the questionnaire sent to all members on June 24, 1943.

The Council held its annual summer meeting at the Samoset Hotel, Rockland, Maine, on Sunday, August 1, 1943.

All Council members were present with the exception of R. V. N. Bliss, M. D., of Blue Hill, President-elect, and Harold S. Babcock, M. D., of Castine, Councilor for the Fifth District, who sent word that he was unable to be present. Guests were Oscar F. Johnson, M. D., Portland, Chairman of the Social Hygiene Committee; Warren E. Kershner, M. D., Bath, a Past President of the Association; and Herbert E. Locke, Esq., Augusta, Association Attorney.

Following considerable discussion, and a study of the 313 replies received to the questionnaire sent to all members of the Association for an expression of opinion relative to holding the regular session of the Association in 1944, which revealed 184 members in favor, 124 opposed, four doubtful, and one vote for a one-day session, the Council voted to hold the regular session on Sunday, Monday, and Tuesday, June 25, 26, and 27, 1944. The meeting to open officially with the First Meeting of the House of Delegates, Sunday afternoon. The Secretary was instructed to contact various hotels for rates and submit same at the next meeting of the Council, at which time the place of the 1944 meeting will be decided upon.

Oscar R. Johnson, M. D., Chairman of the Social Hygiene Committee, in accordance with a vote of the House of Delegates in session June 20th, reported relative to his committees interpretation of the workability of the Infectious and Communicable Disease Law as passed at the last session of the Maine Legislature. Dr. Johnson's report, which is evidence of the careful thought given this question by this committee, will be published in the September issue of the JOURNAL.

Prepaid Medical Service Plans were then discussed at length, and the Council voted to invite J. C. McCann, M. D., of Worcester, Massachusetts, Chairman of the Committee on Prepaid Medical Service, of the Massachusetts Medical Society, to be present at the next Council meeting.

Abbott J. Fuller, M. D., of Pemaquid, Maine, Secretary of the Knox County Medical Society, and a graduate of the University of Vermont in 1907, was appointed Delegate to the Vermont Medical Society annual meeting, usually held in October.

The meeting adjourned at 3.20 P. M., until the fall meeting of the Council to be held at the Copper Kettle, Rockland, Sunday, October 24, 1943.

Proceedings, 1943 House of Delegates

The Proceedings at the First Meeting of the House of Delegates, of the Maine Medical Association, held Sunday, June 20, 1943, at Augusta, as recorded by our reporter, appear elsewhere in this issue. Don't miss this report which contains, among other items of interest, the Budget for 1943-1944, as recommended by the Council and approved by the House of Delegates, the report of Thomas A. Foster, M. D., of Portland, Delegate to the annual meeting of the American Medical Association, and the discussion relative to State dues which were raised from $8.00 to $15.00 at this meeting, and lowered to $12.00 at the Second Meeting of the House held that same day.

Publication of the Proceedings at the Second Meeting of the House of Delegates will commence with the September issue of the JOURNAL.

Maternal and Child Welfare

Anorexia in Children

This symptom probably brings more "well" children to the doctor's office than any other. The mother always wants a "tonic for his appetite," and the physician who does just that will have approximately one hundred percent failures. Anorexia is usually a symptom without organic basis but a complete physical examination should always be done because occasionally a child will be found who suffers from diseased tonsils and adenoids, tuberculosis, anemia, or some chronic infection such as sinusitis or pyelitis. A tuberculin test should always be done, and a careful history of the child's daily life and habits taken. The points to be covered in the history will appear as this article develops. If organic disease is found, the treatment becomes obvious. Do not, however, accept moderately large tonsils as a cause without some other symptoms which make a tonsillectomy advisable, such as chronic cervical adenitis, frequent sore throats, "growing pains," or chronic sinusitis.

The causes of anorexia are usually to be found in the child's habits or in his contacts in the home, play, or school. In early life the child's greatest contact is with his mother, and most mothers suffer from two great misconceptions; an exaggerated idea of the amount of food the child requires, and a conviction that something terrible will happen if a child misses his "three square meals" a day. During the first year the mother has happily watched her baby eat more and more. Sometime during the second year he stops eating "more and more" because he isn't growing so fast, or perhaps for one reason or another he loses his appetite. Now the distressed mother tries with all her might to persuade or force more food on her reluctant offspring. Then others of the family join in the contest with cajolery, games (see if you can eat faster than I can, eat a piece for dolly, etc.), or threats. The once happy mealtime has degenerated into a circus or a fight. If a circus, the child keeps up the game because he loves to be the center of attention. If a fight, the child dreads mealtime, and it is no wonder that the end result is a storm of tears or an attack of vomiting. Sometimes the course of events is less dramatic. The mother simply tries to "make up" by giving lunches, and soon without realising it, is feeding the child every couple of hours. The result is that he is never really hungry and so refuses all food but his favorites.

The treatment of this type of anorexia is directed entirely at the mother. Her mistakes must be pointed out and explained. The physician must be salesman enough to convince the mother that no child has ever starved itself to death, and that, left to himself, he will eat. He must tell the mother to offer three small meals daily, never to urge the child to eat, and to show no concern if he does not eat well. There must be no talk about poor appetite in the child's hearing because children have a strong tendency to live up to a reputation given them. It is not uncommon for a child to announce proudly that he does not eat enough for a bird. Lunches are forbidden. It must be specifically stated that nothing but water may be given between meals, because the mother will not consider that fruit or a few crackers constitute a lunch. Foods that are particularly disliked should not be served, and no effort to improve table manners should be made at this time. The physician will have small chance to convince the mother unless she has seen him do a complete physical examination so that she no longer fears that her child has organic disease. Now he can tell the mother that he will help her by prescribing a tonic, but that she must help the medicine by doing as she is instructed. Iron is useful but the tonic must taste good. The medicine serves mostly as a reminder of the directions given, and as proof that the mother is not struggling along unaided. The above instructions will serve for all cases of anorexia.

Faulty home control is responsible for

many cases of poor appetite. Complete discussion is impossible in the limited space, but three groups will include most of the cases, faulty food habits, inefficient discipline, and mental overstimulation by movies, radio, superman comics, and play with older and stronger children. It is surprisingly easy to drift into the habit of feeding the child too frequently by "making up" for small meals, giving him a cookie to quiet him, or using candy as a bribe, thereby setting up and perhaps firmly fixing faulty food habits. The child will refuse the less interesting foods, knowing that he will have a lunch in a little while. There are of course those who require a lunch, but that comes at a fixed time and does not lessen the appetite for the next meal. In taking the history it is not wise to ask if the child has lunches, as the mother will deny it because she does not consider snacks lunches. Ask what the child has between meals.

Inefficient discipline is the root of much trouble. The discipline which is both persistant and ineffective is especially trying to the child because he is thwarted so frequently by the "don't, don't, don't" of the mother, and yet has discovered that he can have his own way if he makes enough rumpus. Failure to teach the child to play by himself results in overstimulation by adult companions. In older ones certain radio programs, movies, etc., and constant play with older and stronger children are much too exciting. These unfortunate children are all nervously overexcited and it is not surprising that anorexia is a prominent symptom.

The physician will have no success in his treatment of these children unless he takes pains to enquire about the daily family life, and then is willing to spend the time necessary to tell the mother how to improve conditions. She needs encouragement and a stiffening of the backbone. She must have the child eat and go to bed at the proper time, but beyond that, the fewer prohibitions and commands, the better. These once given, however, she must be prepared to follow through. This will lessen the thoughtless nagging which is so unfortunate a part of many children's lives. The menace of radio, etc., can be eliminated by firmness and by substituting suitable reading. The youngster who will not play by himself must be taught by being left for very short times at first. The mother must be told that success is the result of persistent effort just as is success in playing the piano. In some overstimulated children the temporary use of a mild sedative is often very helpful.

In older children by far the commonest cause of anorexia is overfatigue. The history of some of them is startling. Between school, music, dancing, dramatics, church work, and home study many a child puts in a longer day than his father. Others exhaust themselves in strenuous play or athletics. The children in the rural sections who have to go to school by bus and stay all day are especially prone to overfatigue. It is useless to try to help by vitamins and tonics alone. Rest must be secured. A severe case will have to be put to bed for a week. In less severe cases, the child should attend only the morning session of school, come back for dinner, and be put to bed for an hour and a half. All out-of-school activities should be stopped. The ones who must attend a distant school all day may be advised to stay home on Tuesdays and Thursdays, having a nap on those days and on Saturdays and Sundays. These patients usually will begin promptly to do better school work. No effort should be made to get them to eat. They are too tired, and the food that is forced into them will not be digested. As fatigue lessens, the appetite will improve.

It will be seen from the foregoing admittedly sketchy outline that the treatment of anorexia without organic basis depends not upon medicine but upon regulation of the child's daily life. The mother's confidence must be gained by doing a careful physical examination. Her coöperation will be received when she gets a logical explanation of her difficulties, and a program which she can carry out with the sympathetic guidance of the physician. To dismiss these patients with a bottle of tonic and an admonition to the mother not to worry is to miss a great opportunity to help this large group of children.

Your Committee on Maternal and Child Welfare.

New Recommendations on Burns and Wound Infections in Air Raid Casualties

Published by Office of Civilian Defense, Medical Division

The Medical Division of the Office of Civilian Defense has revised its pamphlet "Treatment of Burns and Prevention of Wound Infections" to incorporate new techniques that have been developed within the past year. The recommendations in this pamphlet are based on recent directions of the Committee on Chemotherapeutic and Other Agents and the Subcommittee on Burns of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. Originally drawn up by these committees for the armed forces, the recommendations have been modified to adapt them to the problems involved in the treatment of civilian casualties.

Recommendations for the use of sulfonamides are accompanied by the observation that these drugs must be used more cautiously in the treatment of civilian wounds than is necessary in the care of military casualties, for the following reasons:

"The injured may include individuals of all ages and with various types of pre-existing disease, instead of a selected group of healthy young males. The possibility of toxic effects is therefore greatly enhanced. Moreover, it is assumed that in civilian injuries, hospitalization will be possible in a relatively short time, whereas in military operations such is not always the case. This usually makes it possible to postpone all consideration of chemotherapy until the injured have been hospitalized. It is then possible to administer sulfonamides with better safeguards and to consider such contraindications as other pathological conditions or known sensitivity to individual drugs. The dangers of dehydration can also be better prevented or overcome under such circumstances."

In a discussion of intra-abdominal wounds leading to perforation of the hollow viscera, the revised pamphlet advises sodium sulfadiazine as the drug of choice for parenteral administration, which is considered preferable to oral therapy during the first 48 hours. Sulfanilamide was recommended in the previous edition. Concentrated solutions of sodium sulfadiazine are not recommended for subcutaneous or intramuscular routes, but it is pointed out that weak solutions (0.5%) may be used with little danger of sloughing of the tissues.

Special emphasis is placed on the danger of giving sulfonamide drugs to a patient who is not voiding normally (over 1,000 cc. per day).

"Should circumstances require sulfonamide administration in the presence of inadequate urinary output, the urine should be watched for evidence of renal damage and the dosage of drug adjusted so that a blood concentration as evidenced by daily determinations, not to exceed 10 mg. percent, is maintained," the pamphlet warns. "If further diminution of the urinary output occurs, administration of the drug should be stopped immediately and fluids should be forced orally, if possible, and by means of glucose and water (5 percent in sterile distilled water), intravenously if necessary. If anuria due to bilateral obstruction of the ureters develops, ureteral catheterization and lavage of the renal pelves may be required."

The emergency care of burns is outlined as follows:

"Whenever casualties with extensive burns can be admitted to hospitals without delay, and definitive treatment can be instituted promptly, morphine sulphate, one-half grain, should be administered at the scene of the incident and no local therapy applied to the burned area except sterile gauze to exposed surfaces to prevent infection."

The most notable change in the OCD pamphlet is the withdrawal of the recommendation of the use of ointments or jellies containing tannic acid in the first-aid treatment of burns. The new advice given is that when definitive care cannot be carried out

within two hours, the patient should receive sufficient morphine to relieve pain (not less than one-half grain, except in patients with lung and bronchial damage, the very old or the very young); and the burned surfaces should be covered with sterile boric acid ointment or petrolatum over which one or two layers of gauze of fine mesh (44) is to be smoothly applied. Over this dressing thick sterile gauze or sterile cotton waste is to be placed and the entire dressing is to be bandaged firmly but not tightly. Substitution of jelly containing 5 percent sulfathiazole in water-soluble base, which is supplied in the OCD carrying case A for Mobile Medical Teams, is permissible.

The discussion of definitive treatment of burns has been expanded to stress the necessity for administration of large amounts of plasma.

"In patients with severe burns, quantities up to 12 units or more may be required in the first twenty-four hours," it is pointed out. "To the patient in critical condition, plasma must be given rapidly (as much as 500 cc. in 10 minutes may be necessary) and not allowed to flow drop by drop. It must never be administered by any other than the intravenous route. Syringe injection may be used. If facilities for hematocrit determinations are available, the following general rule can be used for guidance regarding the amount of plasma required. For each point that the hematocrit is above 50 percent cells, at least 100 cc. of plasma should be administered. If clinically satisfactory results are not obtained with this dosage, larger quantities should be given." A footnote points out that rapid administration of intravenous fluids may be dangerous to cardiac patients and that the physician's judgment will have to determine the amount as well as the rate of administration in such cases.

The pamphlet describes "open" and "closed" treatment for burns. The "open" treatment which is now considered the treatment of choice and is especially recommended for treatment of burns of the hands, face, feet, perineum and genitalia, consists essentially of the application of boric acid ointment or petrolatum, with pressure dressings. Such dressings can often be left in place 12 or 14 days.

The "closed" treatment, which is the tanning or eschar method, is particularly indicated in extensive "flash" or second-degree burns of the trunk. This method is recommended only if the following conditions are present: (1) If not more than 24 hours have elapsed; (2) if the burned area has not been grossly contaminated; (3) if strict surgical asepsis is employed in the preparation of the burned surface, and (4) if coagulation is rapidly accomplished, i.e., by combined use of tannic acid and silver nitrate. The method of tanning is described as in the original edition of the pamphlet.

In the new directions, additional emphasis is placed on masking of both the patient and his attendants, in order to minimize the danger of secondary infection.

Nothing is more important at the present time than to continue and to intensify the campaign against tuberculosis and against syphilis, and I hope that no one will permit his attention to be swayed from the objectives we have in mind, because the fight against these diseases is more important at a time of crisis as a measure of national defense than it is in normal times.—Frank C. Boudreau, M. D.

If pulmonary tuberculosis is an insidious personal problem to those growing old, it is also one of the major unsolved health problems of the present day. Any effective approach to it must eliminate the present common attitude of simply sighing at the aged tuberculous patient with positive sputum.—J. T. Freeman, M. D., and C. A. Heiken, M. D., *Amer. Jour. of Med. Sciences,* July, 1941.

COUNTY SOCIETIES

Androscoggin
President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Francois J. Faucher, M. D., Grand Isle
Secretary, Thomas G. Harvey, M. D., Mars Hill

Cumberland
President, J. Calvin Oram, M. D., So. Portland
Secretary, Eugene E. O'Donnell, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Charles C. Morrison, M. D., Bar Harbor
Secretary, Edward Thegen, M. D., Bucksport

Kennebec
President, Adolphe J. Gingras, M. D., Augusta
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Abbott J. Fuller, M. D., Pemaquid

Lincoln-Sagadahoc
President, Rufus E. Stetson, M. D., Damariscotta
Secretary, Albert S. Owen, M. D., Bath

Oxford
President, Lester Adams, M. D., Greenwood Mt.
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Ernest T. Young, M. D., Millinocket
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Maurice S. Philbrick, M. D., Skowhegan
Secretary, Maurice E. Lord, M. D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Arthur J. Stimpson, M. D., Kennebunk
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Aroostook

The Aroostook County Medical Society held its Annual Meeting on Tuesday, June 29th, at the Elks Club, Houlton. Special guests of the evening were Oscar F. Larson, M. D., of Machias, President of the Maine Medical Association, and several officers of the Medical units at both the Houlton and Presque Isle Airbases.

Following a fine salmon dinner, a short business meeting was called by President Thomas Harvey, M. D., of Mars Hill. The meeting was followed by a fine program of speakers covering many new advances made in medicine and surgery by our Armed Forces, as follows:

"Atypical Pneumonia" by Capt. J. R. Bell, M. C., Presque Isle.

"Thrombosis and Embolism" by Capt. M. D. Deren, M. C., Houlton.

"Application of The Strader Splint" by Capt. D. H. Maunz, M. C., Presque Isle.

"Strabismus" by Capt. N. O. Eaddy, M. C., Presque Isle.

"Just Worms" by Clyde I. Swett, M. D., Island Falls.

The following officers of the Aroostook County Medical Society were elected for the coming year:

President, Francois Faucher, M. D., Grand Isle.

Vice President, Clyde I. Swett, M. D., Island Falls.

Secretary-Treasurer, Thomas Harvey, M. D., Mars Hill.

Oxford

Doctor Leslie, Retires—Returns to Maine

Frank E. Leslie, M. D., having reached the age of compulsory retirement in federal service, has returned to Andover, Maine, where he was located from 1905 to 1917 as Superintendent of the Glenellis Sanitarium.

At the time of his retirement in June, 1943, Dr. Leslie was manager of the Veterans' Administration "Memorial Hospital," at Mendota, Wisconsin, a position he had held since October 1, 1939, when he was transferred to Wisconsin from the Veterans' Hospital at Northampton, Massachusetts.

In July, 1917, Dr. Leslie was commissioned a First Lieutenant in the U. S. Army Medical Corps. He was promoted to Captain in October of that same year, and to Major in February, 1918. In September, 1919, he was commissioned a Surgeon in the U. S. P. H. S., and made Senior Surgeon in February, 1920.

Dr. Leslie is a member of the Oxford County Medical Society.

A regular meeting of the Oxford County Medical Society was held at Bethel Inn, Bethel, Maine, June 16, 1943.

The meeting was called to order by the President, Dr. Lester Adams, Western Maine Sanatorium, Hebron.

Minutes were read and accepted.

Sixteen members were present at the business meeting, also two guests: Dr. Frederick T. Hill, of Waterville, Past President of the Maine Medical Association, and Dr. W. J. Turtle, of Newtonville, Massachusetts.

George F. Shurtleff, M. D., of Andover, was elected to membership.

It was voted that a page of the Record Book be inscribed with the names of the members in military service.

There were thirty-nine members and guests present at the dinner.

Dr. Hill, the speaker of the evening, presented a very fine talk on the subject, *Postoperative Atelectasis.*

J. S. Sturtevant, M. D.,
Secretary.

Washington

The July meeting of the Washington County Medical Society was held at the Hotel East in Eastport, Maine, Tuesday, July 20, 1943. A delicious lobster dinner was served at 6.30 P. M., following which the regular meeting was called to order by President Walter N. Miner, M. D., of Calais.

"Heart Disease" was the subject of the evening's discussion, each member contributing from his experiences.

It was quite unique that the presidents of the Maine and the New Brunswick Medical Societies, both members of the Washington County Society were present. They are Dr. O. F. Larson of Machias, and Dr. H. S. Everett of St. Stephen, N. B.

Bill No. 1161, the Wagner Bill, now before the United States Congress was discussed at length. All comments were decidedly unfavorable, inasmuch as enactment of such a bill would end the practice of medicine as we know it today. It was urged that each member of the Society request copies of this bill by writing to Senator Brewster.

Thirteen members of the Society were present. The meeting was adjourned at 10.00 P. M.

Allen H. Knapp, M. D.,
Secretary.

New Member

Aroostook

John R. Webber, M. D., Houlton, Maine.

*Members in Military Service**

Kennebec

Giddings, Paul D., Augusta

* Complete list of names of members in military service, which were submitted to this office previous to May 31, 1943, published in the June, 1943, issue of the "Journal."

For Sale

Medical Library of the late G. F. Miller, M. D. For information write:

Mrs. Daisy C. Miller
27 Northport Avenue
Belfast, Maine

Notices

Annual Meeting
Maine Hospital Association
Waterville, Maine
September 3-4, 1943

The annual meeting of the Maine Hospital Association will be held at the new Mayflower Hill Campus of Colby College, Waterville, Maine, Friday evening, September 3rd, and Saturday, September 4th.

A very interesting program has been prepared.

Tumor Clinics

Bangor: *Eastern Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Magnus F. Ridlon, M. D.*

Lewiston: *Central Maine General Hospital*
Tuesday, 10.00 A. M.-12.00 M.
Director, *E. C. Higgins, M. D.*

St. Mary's General Hospital
Wednesday, 4.00 P. M.
Director, *R. A. Beliveau, M. D.*

Portland: *Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Mortimer Warren, M. D.*

Waterville: *Sisters Hospital*
1st & 3rd Thursdays, 10.00 A. M.
Director, *B. O. Goodrich, M. D.*

Thayer Hospital
2nd & 4th Thursdays, 10.00 A. M.
Director, *E. H. Risley, M. D.*

State of Maine
Board of Registration of Medicine

Adam P. Leighton, M. D., Portland, Secretary.

List of Physicians Licensed in the State of Maine, July 7, 1943.

Through Examinations

Harold C. Amrein, M. D., Lewiston, Maine.
Charles F. Appel, M. D., Portland, Maine.
Eugene G. Auld, M. D., Malden, Mass.
Maurice O. Barney, M. D., Lewiston, Maine.
Reynold E. Burch, M. D., Gardiner, Maine.
John S. Chambers, Jr., M. D., Boston, Mass.
Edward L. Curran, M. D., New York, N. Y.
William A. Dafoe, M. D., Boston, Mass.
Ralph A. Goodwin, Jr., M. D., Auburn, Maine.
John T. Konecki, M. D., Portland, Maine.
Harry L. Kozol, M. D., Boston, Mass.
Edwin M. Leach, M. D., Blue Hill, Maine.
Arthur N. Lieberman, M. D., Brooklyn, N. Y.
Roger W. Morrison, M. D., Boston, Mass.
William I. Wiggin, M. D., Lowell, Mass.

Through Reciprocity

Norman E. Dyhrberg, M. D., Cumberland Center, Maine.
Horace K. Sowles, M. D., Boston, Mass.
Johann A. Reichel, M. D., Champaign, Ill.

Book Reviews

"Synopsis of Ano-Rectal Diseases"

By: Louis J. Hirschman, M. D., F. A. C. S., Ex-Vice President, A. M. A.; Ex-Chairman, Section on Gastroenterology and Proctology, A. M. A.; Ex-President American Proctologic Society; etc., etc., etc.

With 182 Text Illustrations and 12 in Color Plates.

Second Edition.

Published by The C. V. Mosby Company, St. Louis, 1942. Price, $4.50.

This thoroughly revised and slightly enlarged edition is the author's reply to persistent demands from the medical synopsis readers. A new chapter on focal infections of ano-rectal origin has been added. The specific needs of the medical student as well as of the general practitioner have been considered.

"Infant Nutrition"

A Textbook of Infant Feeding for Students and Practitioners of Medicine

By: Williams McKim Marriott, B. S., M. D.; Late Professor of Pediatrics, Washington University School of Medicine; Physician-in-Chief, St. Louis Children's Hospital, St. Louis.

Revised by P. C. Jeans, A. B., M. D., Professor of Pediatrics, College of Medicine, State University of Iowa, Iowa City.

Third Edition.

Published by The C. V. Mosby Company, St. Louis, 1941. Price, $5.50.

The most important contribution which Marriott introduced into the art and science of Infant Feeding was the replacement of empiricism with scientific fundamentals and the simplification of proceeding from these bases. The present edition has remained true to these basic principles and faithfully promoted what is new and serviceable in theory and practice alike.

"Blood Grouping Technic"

A Manual for Clinicians, Serologists, Anthropologists, and Students of Legal and Military Medicine

By: Fritz Schiff, M. D., Late Chief of the Department of Bacteriology, Beth Israel Hospital, New York, N. Y., and William C. Boyd, Ph. D., Associate Professor of Biochemistry, Boston University School of Medicine, etc.

Published by the Interscience Publishers, Inc., New York, N. Y., 1942. Price, $5.00.

This book represents an attempt to give clear and concise directions for carrying out blood grouping tests. Unfortunately the senior author was prevented by an untimely death from himself completing this work which may be looked upon as an extension and translation of his three former works, printed in German. The junior author brought this work to a successful conclusion.

"The March of Medicine"

The New York Academy of Medicine Lectures to the Laity, 1942.

Published by the Columbia University Press, 1943, New York. Price, $2.50.

CONTENTS:

Foreword, by Malcolm Goodridge, M. D.

Introduction, by Herbert B. Wilcox, M. D.

1. Tuberculosis: the Known and the Unknown, The Linsly R. Williams Memorial Lecture, by James Alexander Miller, M. D.
2. The Brain and the Mind, by Tracy Jackson Putnam, M. D.
3. The Freudian Epoch, by A. A. Brill, Ph. B., M. D.
4. Genius, Giftedness, and Growth, by Arnold Gesell, M. D.
5. The History of the B-Vitamins, by Normal Jolliffe, M. D.
6. The Newer Knowledge of Nutrition, by A. J. Carlson, M. D.

Index.

Here, in book form, are the lectures given in the latest series. Anyone, physician or layman, who would enjoy hearing a top-ranking medical expert talk about some phase of his special field will appreciate these essays, in which six authorities discuss, in simple but scientific terms, the background and recent developments of some vital problems of body and mind.

"The Principles and Practice of Obstetrics"

(Eighth Edition)

By: Joseph B. DeLee, A. M., M. D., Formerly Professor of Obstetrics and Gynecology, Emeritus, University of Chicago; Consultant in Obstetrics, Chicago Lying-in Hospital and Dispensary; Consultant in Obstetrics, Chicago Maternity Center; and J. P. Greenhill, B. S., M. D., Attending Obstetrician and Gynecologist, Michael Reese Hospital; Obstetrician and Gynecologist, Associate Staff Chicago Lying-in Hospital; Attending Gynecologist, Cook County Hospital; Professor of Gynecology, Cook County Graduate School of Medicine.

Eighth Edition, Entirely Reset. 1101 pages with 1074 illustrations on 841 figures, 209 of them in colors.

Published by W. B. Saunders Company, Philadelphia and London, 1943. Price, $10.00.

This is one of the leading textbooks on obstetrics for medical students and practitioners of medicine. It contains twelve sections, composed of sixty-two chapters. In this, the eighth edition, new chapters have been added dealing with obstetric and gynecologic endocrinology, the use of Vitamin K, the sulfonamide drugs in obstetrics, and the Waters extraperitoneal cesarean section. Several chapters and sections have been completely rewritten. There is a worthwhile list of references at the end of each chapter.

"The Conquest of Bacteria—From Salvarsan to Sulphapyridine"

By: F. Sherwood Taylor.

Foreword by Henry E. Sigerist.

Published by Philosophical Library and Alliance Book Corporation, New York, 1942. Price, $2.00.

In spite of the fact that the physicians have employed drugs for many centuries the scientific methods of chemotherapy have been evolved only some thirty years ago and actually and successfully employed for much less time than that. In this small volume the author tries to show the progressive development of bacteriocidal chemotherapy as it began with Ehrlich's "606" and finally flowered into full bloom as the Domagk's Sulphonamide bouquet which is constantly enlarged by the addition of new masterpieces of synthesis accomplishment.

"Military Surgical Manuals Volume VI—Neurosurgery and Thoracic Surgery"

Prepared and Edited by the Subcommittee on Neurosurgery and Thoracic Surgery of the Committee on Surgery of the Division of Medical Sciences of the National Research Council.

Published by W. B. Saunders Company, Philadelphia and London, 1943. Price, $2.50.

This volume is the last in a series developed under the auspices of the Division of Medical Sciences of the National Research Council to furnish the medical departments of the United States Army and Navy with necessary information in the field of military surgery. This volume is divided into two parts; part one on neurosurgery which contains five chapters, and part two on thoracic surgery which contains four chapters. Although this manual was designed for medical officers caring for wounded men under enemy action, it will be found to have unlimited value for physicians who are not in military service.

"Mental Illness: A Guide for the Family"

By: Edith M. Stern with the collaboration of Samuel W. Hamilton, M. D.

The Commonwealth Fund, 1942, New York. Price, $1.00.

The purpose of this book is to point out to the laity, and other members of a family in which there is a mentally ill member, the present scientific conception of the illness. Mental illness is pictured as no different from any other type of illness, and the error of feeling disgrace and shame is emphasized. This book should be read by all persons who have to deal with the mentally ill.

"Reports of the Council on Pharmacy and Chemistry"

Issued under the direction and supervision of the Council on Pharmacy and Chemistry of the American Medical Association. Price, $1.00. Pp. 207. Chicago: American Medical Association, 1943.

This volume epitomizes that phase of the Council's work which may be said to be collateral to the "acceptance" of drugs,—the informative consideration of current medical problems in the interest of rational therapeutics. It contains reports of studies by private investigators which were originally published in THE JOURNAL under the sponsorship of the Council such as preliminary discussions of new developments in therapeutics and timely articles on the status of recognized agents as well as reports of omission or rejection of products from New and Nonofficial Remedies. It also offers a record of current decisions on matters of Council policy.

Several of the reports are of particular interest for various branches of medical science: the use of bulk ether in anesthesia, the absorption of surgical gut (catgut), the higher types of antipneumococcus rabbit serum, the surgical and medical treatment of animals with experimental hypertension and the status of racemic epinephrine solutions for oral administration. The reports in this small compact volume represent expert medical concensus and are proffered to aid in the consideration of the value of therapeutc agents.

"A Textbook of Clinical Neurology"
(Fifth Edition)

By: Israel S. Wechsler, M. D., Clinical Professor of Neurology, Columbia University, New York; Neurologist, The Mount Sinai Hospital; Consulting Neurologist, The Montefiore and Rockland State Hospitals, New York.

Fifth Edition, revised. 840 pages with 162 illustrations.

Published by W. B. Saunders Company, Philadelphia and London, 1943. Price, $7.50.

This is a valuable textbook on clinical neurology, completely up to date, based mainly on personal teaching and clinical experience of the author. It is divided into five parts: Methods of Examination, The Spinal Cord, Peripheral Nerves, The Brain, and The Neurosis.

During the four years since the last edition was published there have been a number of advances in neurology. Chemotherapy of meningitis is practically new, headache is better understood, and degenerative diseases and the autonomic nervous system have all received further study.

Proceedings

MAINE MEDICAL ASSOCIATION

House of Delegates

AUGUSTA, MAINE ❦ JUNE 20, 1943

FIRST MEETING OF THE HOUSE OF DELEGATES, JUNE 20, 1943

The first meeting of the House of Delegates of the Maine Medical Association convened at the Augusta House, Augusta, Maine, on Sunday, June 20, 1943, at eleven o'clock in the forenoon, with Dr. Oscar F. Larson, of Machias, Council Chairman, presiding.

CHAIRMAN LARSON: The meeting will please come to order. The first business to come before the meeting is the roll call by the Secretary, Dr. Frederick R. Carter, of Portland. (Secretary Carter then called the roll and the following delegates responded.)

First District:

Cumberland County:—William Holt, M. D., Portland; Benjamin Zolov, M. D., Portland; Thomas A. Foster, M. D., Portland; Frank A. Smith, M. D., Westbrook. Alternate: Oscar R. Johnson, M. D., Portland.

Second District:

Androscoggin County:—Ralph A. Goodwin, M. D., Auburn; William H. Chaffers, M. D., Lewiston.

Franklin County:—George L. Pratt, M. D., Farmington.

Third District:

Knox County:—C. Harold Jameson, M. D., Rockland; James Carswell, M. D., Camden. Alternate: Abbott J. Fuller, M. D., Pemaquid.

Lincoln-Sagadahoc Counties:—James W. Laughlin, M. D., Newcastle. Alternate: Warren E. Kershner, M. D., Bath.

Fourth District:

Kennebec County:—Roland L. McKay, M. D., Augusta; Maurice A. Priest, M. D., Augusta.

Somerset County:—Walter S. Stinchfield, M. D., Skowhegan.

Waldo County:—Foster C. Small, M. D., Belfast.

Fifth District:

Hancock County: — Edward Thegan, M. D., Bucksport.

Washington County:—Willard H. Bunker, M. D., Calais.

Sixth District:

Penobscot County:—Ernest T. Young, M. D., Millinocket; Frank D. Weymouth, M. D., Brewer; Samuel S. Silsby, M. D., Bangor; Leroy H. Smith, M. D., Winterport. Alternate: Forrest B. Ames, M. D., Bangor.

Piscataquis County:—Ralph C. Stuart, M. D., Guilford.

CHAIRMAN LARSON: The Reference Committee will be composed of the following men: Drs. Frank A. Smith, Frank D. Weymouth and Leroy H. Smith.

The Nominating Committee, as appointed by the President, is as follows: First District, William Holt, who will act as Chairman; Second District, George L. Pratt; Third District, C. Harold Jameson; Fourth District, Foster C. Small; Fifth District, Willard H. Bunker; Sixth District, Leroy H. Smith.

The next order of business is the reading of the report of the Council for 1942-1943.

(Chairman Larson then read a resume of the Council Meetings held at Poland Spring, June 23, 1942; Belfast, July 26, 1942; Waterville, October 25, 1942; Augusta, April 11, 1943; and of council business transacted by mail. This report is on file in the Association Office at Portland.)

The Fifth meeting of the Council was held at ten o'clock this morning, at this hotel. At this meeting the budget for 1943-1944, which follows, was approved by the Council for presentation to the House of Delegates.

President's expenses	$ 300.00
Salary of Secretary-Treasurer	1,200.00
Assistant Secretary	2,000.00
Office expenses	1,000.00
Medical Advisory Committee	500.00
Graduate Education	100.00
State Delegates and Council	250.00
Delegate to A. M. A. Annual Session	250.00
Annual Session	100.00
Appropriation to the Editor of the JOURNAL	1,000.00
Expenses not covered by advertising	500.00
The total of the budget is	$7,200.00

There was also read at this meeting several letters, one of which was from Dr. Stephen A. Cobb, President-elect, who is now in England with the 67th General Hospital.

There was also the report relative to the citizens of Dover-Foxcroft voting, at a special town meeting, to have only medical men practice in the Mayo Memorial Hospital, a community hospital.

SECRETARY CARTER: You have heard the report of the Chairman of the Council. What do you wish to do about it?

DR. WILLIAM HOLT of Portland: I move the acceptance of the report of the Council.

This motion was duly seconded.

DR. THOMAS A. FOSTER, Portland: Mr. Chairman, I think the time has come when the Association should bear in mind the expenses under which we are laboring. Those of you who have read your report will know that this year, there is a deficit of about $800.00. It is true that we have some money in the bank, and we can use the money in the bank. But that money in the bank isn't going to last forever.

I think that before we accept this report, it would be wise to have some discussion. I think that the Council has made out a budget which is proper and carefully considered, but I think that they are spending the money of the members of the Association, and I think that the members of the Association and the Delegates of the County Societies should be heard on these expenses, if they have anything to say.

There are two items in the budget which interest me. The first is the generous appropriation made to the delegate to the A. M. A. Annual Session, which of course doesn't necessarily need to be spent, and which I think probably could be lower than it is here. Probably the meeting will

be at Kansas City, and I think $250.00 would be more than enough to pay the expenses of that delegate. I think that we might consider making it $200.00.

Now, as to the expenses of the JOURNAL, you have all heard me sound off on this before. During my time when I held office in the Association, it always seemed to me that the salary of the Editor was pretty good, considering the time that the Editor was asked to put in on the JOURNAL.

I should like to have you consider these two items. I don't think that these items are particularly high, but I think that we should consider them before we vote the acceptance of the report as a whole. I realize that some states pay a full-time man to be Secretary of the State Association and edit the JOURNAL, as high as $10,000, but those are the larger State Associations, and the Editor and Secretary-Treasurer give it their full-time and results are produced which are worth the $10,000.

I think that if we are going to have a budget which is a little larger than our income all the time, we are going to go "in the hole" so to speak, and there are only two ways to make it up. One is to take the money out of the reserve, which we may need in the future; the other is to increase the dues.

I simply ask you to consider these items before you adopt them in a blanket way. I think it is better to consider them now than to complain about them later.

CHAIRMAN LARSON: Has anybody else anything to say about the budget. We should like to hear from every member present.

DR. GEORGE L. PRATT, Farmington: Mr. Chairman, if I might be allowed to give the report of the Financial Advisory Committee, which met today, it is very much in line with what Dr. Foster has recommended.

We should like to renew the recommendation that we made last year, that the Council consider the advisabilty of investing some of our surplus funds in war bonds.

We call attention, also, to the deficit of $800 to $900. It doesn't seem to the Advisory Committee that we should go on running behind $800 to $900; therefore, we do recommend to the Delegates and to the Council that they consider methods of reducing the expenses or increasing the dues.

CHAIRMAN LARSON: Does any one else wish to discuss this matter?

A MEMBER: I should like to make the suggestion that perhaps the better way out of this situation is to raise the dues, because at this time most physcians are more able to pay their dues to maintain the medical association.

DR. LEROY H. SMITH, Winterport: I am not sure that we can get more. I really think that our dues are very small in comparison to what we get and what we expect of the Association. A few years ago, the dues were raised. At that time, I was President of the Penobscot County Medical Society, and I was surprised at the number of men who sent in a written or verbal protest against this increase in the dues, . . . but they did put up an awful fight against the increase in dues, when we raised the dues to $10.00 a year.

I am not against raising the dues; I think it is a good idea. But I think there will be a strong protest over the State about it.

DR. GEORGE CAMPBELL, Augusta: Mr. President, as one of the older members of the Association, I feel that it would be much more in keeping with our past to raise the dues than it would be to cut down the expenses of the men who are working for us and who are doing good work. We all have to admit that those of us who are left here on the home front and have not gone into the service are doing a little more business; we are earning a little more money, and the common people are a little better able to pay us; consequently, collections are, with me, and I hope for the rest of you, a little better, in proportion to the amount of work done.

I would be in favor of raising the dues.

DR. WARREN E. KERSHNER, Bath: We did truly get quite a lot of criticism, as Dr. Smith said, when we raised the dues before. I wonder if some of us realize that there are only one or two states in the Union with dues as low as ours. As a matter of fact, some of the County Societies charge $25.00 a year, just for the County dues alone!

I have never felt that we appreciated the value of the State Association, and this has come to my attention more forcibly this year, when very unfortunately we have not had an annual session. On the other hand, there seems to be no particular reason why the dues should have been reduced from $10.00 to $8.00; that was about eleven years ago, and I think that was done because one or two who never have been interested enough in the Association to attend regularly got their heads together and thought the dues were too high. I think Tom Foster and two or three others were members of that group, and they decided to reduce the dues; they wanted to get them down to $5.00, but they compromised and the dues were $8.00.

I think that there should be a pretty thorough check-up of our financial status, and I might say that I think there should be something added to the JOURNAL by those who know how so that we may have a little more pep in the JOURNAL and make it more interesting for the average man to read consistently.

Therefore, it seems to me that additional dues would be one way out of these financial difficulties which would be sound at least.

DR. FRANK A. SMITH, Westbrook: As ordinary delegates, we don't know much about the financial set-up. I certainly think we ought to raise the dues in order to keep abreast of the expenses. I know that we have the utmost contempt for the way the government is running so many things and going into debt so extravagantly. I don't believe that we ought to do that. I believe we ought to raise the dues and keep abreast of our expenses, and I also think that we should have a meeting each year in order to keep up the interest of the medical men. If anybody in the State needs a couple of days to get away from business, it is the medical men in the State, and I think it is very unwise not to have the Annual Meeting.

DR. FOSTER: Mr. Chairman, to bring the thing to a head, I didn't want to switch the discussion to a question of whether or not we should raise the dues at this time, but if we are going to accept the budget as it is, I think we may need to raise the dues. My point was to have the items of the budget discussed; apparently, there is no further discussion on that, so I am prepared to move for the question.

CHAIRMAN LARSON: The question is, whether we shall accept the report of the Council, and the budget is included in that report.

DR. JAMES A. CARSWELL, Camden: I move that we accept the report of the Council.

This motion was duly seconded.

DR. KERSHNER: As as Alternate, may I make a suggestion. I would like to suggest that where some interest has developed in the financial side of the picture, acceptance of this report be deferred to the next meeting of the House of Delegates this afternoon, and then in talking the matter over among ourselves, it can be decided by the

feelings of the group whether we want to accept it as it is and raise the dues, or whether we want to cut down somewhere. This is merely a suggestion; I have no right to make a motion.

CHAIRMAN LARSON: There is a motion before the house and it has been seconded.

DR. FOSTER: You mean, Dr. Carswell, that the budget be accepted in a blanket manner, and not item by item.

DR. CARSWELL: Yes, as it is included in the report of the Council.

CHAIRMAN LARSON: If it is the mind of the members of the House of Delegates to accept this report as read, will the members please make it manifest by raising their hands. Those opposed? *The majority* of those present raised their hands, and the motion was carried.

CHAIRMAN LARSON: The next order of business is the report of Dr. Thomas A. Foster as Delegate to the annual meeting of the American Medical Association.

DR. FOSTER: Mr. Chairman, Members of the House of Delegates and Distinguished Guests. It was my pleasure to attend the meeting of the House of Delegates of the American Medical Association at the Palmer House in Chicago on June 7th. Here is a report, in part, of the proceedings of the House of Delegates.

Promptly at ten o'clock, Dr. Olin West, Secretary, called the roll and revealed a quorum, and the business started immediately. The Reference Committee on Credentials reported that out of 175 delegates eligible to seats in the House of Delegates, 170 delegates were registered. That is a splendid record. The absent delegates were those from Alaska, Porto Rico, the Canal Zone and the Philippines, and the Hawaiian delegate. So there was almost a 100 per cent attendance at this meeting.

The first business was the selection of the recipient for the Distinguished Service Award, which is determined each year by a vote of the House of Delegates. Three candidates were presented by the Board of Trustees, the Chairman of which is Roger I. Lee of Boston. The following names were presented:

A. J. Carlson, Surgeon, of Chicago; Elliott P. Joslin of Boston, whom you all know, and Torald Sollman.

On the first ballot, Dr. Joslin got a sweeping majority and was elected to receive the distinguished service award.

Next, the Speaker of the House of Delegates gave the keynote address. He emphasized the importance of statesmanship of the profession and the statesmanship of the doctors during the war period, urging all members to maintain the high standards achieved by the profession, and not to let the medical profession disintegrate or slip in the emergency.

General Rankin, the retiring President, reported for the profession on the whole as to the need of men in the armed services, and he said that in all probability, fifty per cent of the medical profession would be called into the service in one form or another.

The President-Elect, James E. Paullin, spoke at some length regarding the plans to have special courses of study ready for doctors upon their discharge from the military service, and he bespoke the interest of the members of the profession, particularly on the home front, in the future of our colleagues now serving in the armed forces.

Dr. West, the Secretary, stated that the Association was in good condition. The membership list carried as of April 1, 1943, 122,741 names, an increase of 2,040 over April, 1941, two years ago. Maine has on the official records 751 members. Of these, only 381 are Fellows.

The Treasurer's report was a good report, also. The gross income from all sources for the fiscal year ending December 31, 1942, was $1,975,236.30, an increase of $36,108.91 over the amount of gross income reported for 1941. The total expenditures were $1,644,820.96, a decrease in expenditures of $70,958.79. Receipts from the sale of advertising space in the JOURNAL amounted to $1,036,571.59, an increase in receipts of the sale of the advertising matter in the JOURNAL of $26,717.63, making a net income for the year of 1942 of $330,415.34. That is quite a big business. The net paid weekly average circulation during the year of the JOURNAL was 101,993 copies.

The Board of Trustees made a long report, covering all the activities of the Association. A full report is published in the handbook and it is a report which would interest every member of the Association; this handbook will be left in the office of the Secretary, so that if anybody wishes to read it, he may do so. I would suggest that the Secretary might forward this by mail to members of the Association, who requested it. There are not many handbooks published because of the scarcity of paper.

Some parts of the report I should like to mention here. First, it spoke about the decision of the Supreme Court in regard to the case involving the Medical Society of the District of Columbia and the American Medical Association. As you doubtless remember, the decision of the Supreme Court of the United States in regard to the case involving the Medical Society of the District of Columbia and the American Medical Association was announced on January 18, 1943, and was published in the JOURNAL on January 23, 1943. On the advice of counsel a check for $2,500 has been sent to pay the fine assessed by the District Court against the American Medical Association. Following further advice of counsel, analysis or interpretation of this decision has not been made. So don't ask your delegate to interpret the decision.

The policies of the American Medical Association, standardization of medical education, hospitals, and other aspects of medical care, are established by the House of Delegates.

In the conduct of its defense in this case, the Board of Trustees acted on the authority of the House of Delegates, in each instance given unanimously. There, the case rests.

Then followed a report on the pre-payment service plan. The following states have plans in operation: California, New York, which has three, New Jersey, Michigan, Pennsylvania, Colorado, North Carolina, Oregon, Washington and Massachusetts. There is a long report in the handbook on this matter.

In conclusion, the report said:

"Professional supervision of all the standards of medical service must be made one of the dominant features of pre-payment service, as it always has been of private practice."

Then there was a special report of a sub-committee with representatives of the American Hospital Association, the Catholic Hospital Association, the Protestant Hospital Association, and representatives of the International Society Committee for Radiology and the American Academy of Radiology. This long report was given by a sub-committee. The Chairman deals with the policies of the American Medical Association affecting the sale of medical services by hospitals, sales of X-ray and laboratory services in the Blue Cross and other hospital plans. It is an exhaustive re-

port, and it will be available, at the Association office, to any one who wishes to read it.

In conclusion, the report says:

"In 1937, the House of Delegates approved the following principles, that a subscriber's contract should exclude all medical services. The contract should have provisions that are limited exclusively to hospital facilities."

Then it goes on to say:

"Certainly, this statement is clear, and until changed by the House of Delegates represents the policies of the American Medical Association."

That is the conclusion of the report of the subcommittee. The argument seemed to be the question of whether or not the hospitals should engage in a contract which permitted the subscriber to expect X-ray care and laboratory care by the payment of the bill to the hospital. In other words, whether the hospital would give the X-ray and laboratory service.

Following these reports, resolutions were introduced for reference to the various committees. There were many resolutions along the pattern of the one presented and approved by our Council; that is, the resolution to maintain a bureau in Washington. They were all aiming at the establishment of a committee or bureau to function in Washington, as a center of information about medicine and the achievements of the medical profession. These were introduced by New Jersey and Oregon and by the National Committee on Medical Care in New York and, I think, in some other states. Dr. McGoldrick of New York, Chairman of the Committee to which it was referred, brought in a report, amalgamated with the other resolutions opposing and approving the establishment of a council called the Council on Medical Service and Public Relations, and recently released from the A. M. A. this clipping:

"The American Medical Association House of Delegates approved, at the Annual Convention this week, the formation of a Council on Medical Service and Public Relations . . . " Then it continues: "which will investigate matters pertaining to the economic, social and similar aspects of medical care for all the people." Further, it says: "and suggest means for the distribution of medical services to the public consistent with the principles adopted by the House of Delegates. The American Medical Association has a reputation for conservatism, in particular toward group and coöperative medicine, and that reputation has been enhanced by the wide-spread publicity given the Government's anti-trust case growing out of its attitude toward the Group Health Association in Washington. The Supreme Court recently ruled against the American Medical Association in that case. It is, therefore, especially gratifying, to find the American Medical Association recognizing the very considerable body of opinion within the profession and outside the profession which favors wide-scale development of a program for health insurance or some form of prepaid medical and hospital care. The President of the American Medical Association remarked that the new Council represents 'a great step forward.' "

This article continues: "It is a step which the country's national organization of medical men needed to take. Various studies and programs in the field of prepaid health care are now being carried on in the country, and the keen interest in the aspects of the Beveridge Plan demonstrated here that medical care should be made increasingly available to all citizens, under reasonable rates and reasonable terms of payment. Such programs necessarily entail new types of medicine and hospital practice, and therefore, new criteria. There will no doubt have to be more supervision to insure high standards of service."

Therefore, this bureau will be created by the Board of Trustees, the first year, the President and the President-Elect and the Secretary of the Association, serving ex-officio with the Council. Then, the members will be elected by the House of Delegates in the following years.

This was the most discussed issue in the House, but in its final form as proposed, this Council on Medical Care Service and Public Relations received the unanimous approval of the House of Delegates.

Your delegate was instructed to vote for such a proposal by the Council.

There was a resolution proposed by a delegate, who wore a Navy uniform, to the effect that the delegates approve the idea of a special war time dues for men in the service, in place of the complete abrogation of dues. This proposal was defeated. It was recognized as a generous proposal by the men in the service, but the House of Delegates felt that they should not be called upon to pay dues.

There was a resolution approving courses in biology in all high schools.

Other resolutions regarding the standardization of schools for medical secretaries and medical technicians were approved. The standards are extremely high. That material will be in the Secretary's office.

During the session, the new Surgeon-General, Dr. Kirk, addressed the House of Delegates and made a favorable impression. He is a scrappy little fellow and he certainly had plenty of fight in him. He stated that battle casualties in North Africa had not exceeded 2½ to 3½ per cent of all wounded, and that is a remarkable record. He stated that this was due to plasma, the sulfonamides and rapid transportation. He made a plea for doctors called into the service to be patient during the lulls; he said they would have to be like firemen in the firehouse; there might not be much to do for many days, but he promised plenty of action before the thing was over.

General Grant, Chief of the Air Force Surgeons, spoke about the experience of his branch of war medicine and the vastness of that service. He had a very interesting report on the work being done in that particular branch of medicine.

The House was reapportioned, as a result of which Connecticut, New York and Pennsylvania acquired one more delegate. Dr. Arthur T. McCormack, whom many of you will remember, was Secretary of the Committee, and he was called upon to report. He said that the House was reapportioned last year, but he was told that he was in error. After considerable discussion, and after being told that he was still in error, as he was the continuous delegate from the State of Kentucky, he was reluctant to bring in a report. But he went out and finally came back and announced that the States of Connecticut, New York and Pennsylvania acquired another delegate, and Kentucky, North Carolina and South Carolina lost a delegate.

At the last session, Dr. Herman Kretchmer, for many years Secretary of the Association, was elected President. Dr. John Ameese, pediatrician of Denver, was elected Vice-President; Drs. Brasch and Irons, Trustees, and Dr. Olin West as Secretary and Acting Treasurer. The Speaker of the House, Dr. Shoulders, was re-elected. The House elected to have the 1946 meeting held in San Francisco.

Thank you for your attention to this rather long report.

Chairman Larson: Thank you very much, Dr. Foster, for your very comprehensive report.

If there is no discussion of this report, and no questions to be asked, then the next order of business will be the report of any Standing Committee not published in the JOURNAL.

SECRETARY CARTER: The only report not published was that of the Committee on the Survey of Hospitals and Medical Care, and the Chairman of that Committee, Dr. S. Judd Beach of Portland, told me he had nothing to report this year.

CHAIRMAN LARSON: We shall now pass along to the reports of special committees, not submitted for publication in the June issue of the JOURNAL.

SECRETARY CARTER: The only Special committee report not published was that of the Committee on Conservation of Vision, and Dr. Kershner, Chairman of that Committee, said that the Committee was operating at such a long-range viewpoint that little could be accomplished in a short time; therefore, there was nothing to report.

There are no other special committee reports at this time.

CHAIRMAN LARSON: Is there anything to come up under new business?

DR. FOSTER: Mr. Chairman, if it is proper at this time, I should like to move that the privilege of the floor be extended to alternate delegates of the county societies and distinguished guests.

This motion was duly seconded and was carried.

CHAIRMAN LARSON: Is there anything to come up under the subject of new business?

DR. HOLT: I think that we should give consideration to the men in the service, so that I think it would be unwise to make the dues too small. Therefore, I move that for the duration at least, the dues be $15.00, plus the county dues.

The motion was duly seconded.

QUESTION: Is that amount necessary?

SECRETARY: We have 174 men in the service; we have 541 active members.

DR. FRANK A. SMITH: Financially, I would like to know where that puts us?

SECRETARY CARTER: On our present paying membership that will give us $8,716.00. Our budget calls for $7,200.00. That will give us $1,500.00 more than our budget calls for.

CHAIRMAN LARSON: We will need to draw some from the surplus this year, I think.

DR. FRANK A. SMITH: We certainly need a surplus. I think that the men in the service, when they come home, will have a darned hard time getting started. I know what it was after the last war. And we ought to be able to help the men when they get back; they will need it.

CHAIRMAN LARSON: There is a motion before the house, which has been seconded, that our dues be raised to $15.00 this coming year, and as long as the war lasts. Is there any further discussion? If not, if that motion meets your mind, please make it manifest in the usual manner. Those opposed?

There was one dissenting vote; therefore, the motion was carried.*

(Secretary Carter then read a letter which he received from Dr. Stephen A. Cobb, President-elect.)

DR. FOSTER: I move that the Secretary acknowledge Dr. Cobb's letter officially, with the appreciation of the members of the House of Delegates, and wishing him continued health and success.

This motion was duly seconded and was carried.

CHAIRMAN LARSON: Is there any other business to come before the meeting this morning? If not, a motion to adjourn is in order.

DR. SMITH: I move that we adjourn, until 4.30 o'clock this afternoon.

This motion was duly seconded and was carried.

(Whereupon, an adjournment was taken at 12.30 o'clock noon, the meeting to be resumed at 4.30 o'clock in the afternoon.)

* At the Second Meeting of the House of Delegates it was voted to make the State dues $12.00, plus county dues.

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*Peripheral Vascular Disease and Its Treatment by Interruption of the Sympathetics**

By Samuel C. Harvey, M. D.**

Only a few years ago it would have been possible to cover the field of surgery of the sympathetic nervous system in the brief time allotted to the discussion today. Even at that, most of this would have been theoretical and controversial. So rapid has been the enlargement of our knowledge, particularly that having to do with its application, that today one must select some one part of it, or the discussion will be too discursive to serve its purpose.

Under this limitation, it has seemed advisable to confine these remarks to the sympathetic system as a factor in certain disorders of the peripheral blood vessels and the place of surgery in their treatment. Such are in general injuries of the larger vessels, obliterative disease, and thrombophlebitis. All of this is or will be sufficiently common as well as important from the standpoint of the disability they may cause, to be of interest not only to those especially informed in this field, but to all engaged in the practice of medicine.

By dealing only with the peripheral vessels the problem is simplified in several ways. The parasympathetic division of the autonomic system which is concerned for the most part with only the organs of the thorax and abdomen may be disregarded in this discussion. Likewise the positive vasodilator component of the sympathetic system may, for practical purposes at least, be ignored and its function considered as that of maintenance of a degree of tone of the peripheral vessels sufficient for an adequate circulation. Lastly, the surgical procedures are limited to those which produce a break in the vasoconstrictor reflex arc.

To put it simply, there seem to be three levels, the lowest intrinsic within the plexi about the vessels, the second and intermediate through the ganglia, and the third and highest through the central nervous system. All of these may be thought of as reflex pathways for they are involuntary in their action, activated by afferent stimuli and effective through efferent impulses.

The lowest level is the less tangible, and it may be doubted whether any neurogenic factor is involved at all. However, direct stimu-

* Read before the meeting of the Maine Medical Association, Poland Spring, Maine, June 23, 1942.
** From the Department of Surgery, Yale University School of Medicine, New Haven, Connecticut.

lation of arteries and veins, and their smaller distributors whether mechanical or electrical will give rise to a local constriction, and the stripping of the adventitia of the larger vessels, the operation of LeRiche, produces a dilatation of at least the area immediately involved. Moreover, when the sympathetic trunks are interrupted, the vessels still remain responsive to adrenine, indeed, more so, the action of this being upon the smooth muscle rather than the nervous structures. It may be, but proof of this is difficult if not impossible, that the plexi under these circumstances still function at a local level in maintaining a basic tone, to which this hormone adds further impetus.

Much more definite and better understood is the reflex arc of the second level, composed of the afferent impulses, corresponding in general to the sensory of the somatic system, and the efferent impulses discharged through the thoraco-lumbar ganglia. These are so distributed that section of the sympathetic cord below the third thoracic ganglia will interrupt the vasoconstrictor impulses to the arms and of the lower lumbar ganglia will cause the same effect in the legs. The terminal distribution to the vessels follows that of the somatic nerves, which give off to and receive filaments from vessels in the segmental neural areas. The nature of the afferent or "sensory stimuli" is not so well understood. Every surgeon working under local anesthesia is familiar with the exquisite sensitivity of vessels which have not been included in the infiltration, but that there are other stimuli which are not painful originating in the vessels seems highly probable. Certain of these are well-known, as those arising in the carotid and aortic plexi which serve to regulate the blood pressure. It may well be that similar mechanisms are present in the peripheral vessels sensitive to conditions induced by changes in the blood and its circulation. It is fairly certain, however, that ordinary sensory stimuli do not pass centralwards through the sympathetic system, but through the somatic nerves.

The third and highest level is that oriented in the diencephalon, whose functions have been so greatly elucidated in the last decade. From the viewpoint of surgical treatment of disorders of the peripheral vessels, this level is as yet insignificant, and indications for interrupting the tracts within the cord and brainstem are not yet apparent. Insofar as it is concerned with the heat regulatory mechanism of the body as a whole, it is of importance in certain tests for vasomotor flexibility which will be discussed later.

The disorders of the peripheral vessels which are concerned in this discussion, may be functional or structural, but are most frequently both. An instance of the former is Raynaud's disease in its earlier stages before extreme vasoconstriction has been sufficiently long maintained to cause damage to the tissues involved including the vessels. An equally rare manifestation of extreme vasoconstriction is that encountered occasionally in the "scalenus syndrome" where compression of the lower cord of the brachial plexus by the subclavian artery against a cervical rib or an analogous vestigeal remnant, gives rise to vasoconstriction. Either of these can be cured by section of the appropriate preganglionic rami. They serve as examples of extreme vasoconstriction, resulting in Raynaud's disease from stimuli arising at a high level, in the "scalenus syndrome" from those introduced by a local focus of irritation. Both may lead in the last analysis to serious structural damage.

A simple form of initial vascular damage is that caused by ligation of a vessel, preferably one of the main trunks where the loss of flow is not readily compensated for by free anastomosis. Some years ago in our laboratory Mulvihill[3] found that on ligation of the analogue in the dog of the common iliac artery in man, the temperature of the footpad of the leg involved rapidly fell to that of the room temperature and remained there for many hours or in a few instances until necrosis took place. According to the traditional concept there was a lack of adequate collateral vessels, so that circulation was not maintained or was not fairly promptly restored. It was found, however, that if the lower lumbar sympathetic ganglia were excised or blocked with procaine the footpad temperature rose at once and with great rapidity to levels approximating those of the control limb. The only deduction apparent

was that mechanical or chemical section of the lumbar sympathetics shut off a flow of vasoconstrictor impulses inasmuch as vasodilator stimulation could not well arise from such procedures. The cause of the vasoconstriction might have been the stimulation of the ligature but this was made improbable by the injection of the adventitia of the vessel with procaine before its application. Pain from the initially deficient circulation seemed unlikely as the source of the vasoconstriction, for the animal was well anesthetized with a barbiturate. Therefore it seemed probable that the vasoconstriction arose from a lowering of the blood pressure and an anoxia. It is the case then that in this experiment on the dog, the reflex vasoconstriction determines the structural damage, and that the interruption of the sympathetic pathways leads at once to a return of the circulation.

In our own clinic we have not had the opportunity to test this thesis on man, but it has been done elsewhere, notably by Ochsner and Gage.[4] The latter writes in a discussion of the treatment of injuries to blood vessels that "When a patient has an injury in the peripheral vascular tree, the peripheral pulse should be thoroughly investigated. If it is absent, vasomotor spasm is present and is of major importance. Regardless of the type of vascular wound, blocking out the sympathetic ganglionated chain by chemical means (1 per cent novocain, or novocain and alcohol, 95 per cent) is urgently indicated. Sympathetic block should be repeated once or twice in the twenty-four hours and continued until arteriovenous spasm has been overcome and the tissues distal to the injury are adequately nourished. For the lower extremity, the first to the fourth lumbar sympathetic ganglia should be blocked, and for the upper extremity the stellate ganglion should be injected. We have used this method in all traumatic injuries of the peripheral vessels as well as for aneurysms for the past twelve years without the occurrence of a single case of ischemic gangrene." Similar experiences with aneurysms have been reported by Bird, White and Smithwick and Richards and Learmonth.[5] The aneurysm offers a more complicated picture than that of ligation alone, for important collaterals may be involved, and there may be also material obstruction from clot. Nevertheless, it is apparent that even in these circumstances, the concomitant vasoconstriction present or that induced by the operative procedure should be met by a block of the appropriate sympathetics.

A somewhat analogous situation arises with embolism of the larger vessels. where at certain locations a complete block leads with considerable frequency to gangrene. Under these circumstances the accepted procedure is to remove the embolus at the earliest possible moment, and to employ heparin for the prevention of further progress of thrombosis. This is probably sound; at least sufficient experience has not accumulated to justify doing otherwise. Nevertheless, here also there is a considerable component of vasospasm, the abolition of which by a sympathetic block could not be other than beneficial. Certainly, in those instances seen late in which a progressive distal thrombosis is taking place, and where embolectomy does not succeed in clearing the artery, it should be done and followed by heparinization.

Quite apart from the active block of the circulation by an embolus, injury to the vessel wall, or a contusion leaving no evidence of injury may lead to a constriction of it over a considerable distance and even into its branches and collaterals sufficient to produce gangrene. That this is the mechanism of Volkmann's contracture has been ably proved by the observations of Griffith and Foisie. Here the deficient circulation as shown by the appearance of ischaemia and the absence of the radial pulse, leads to a necrosis of the muscles of the forearm. A sympathetic block at the stellate ganglion may be effective but more often it is not, and it is necessary to expose the brachial artery promptly. This will usually show a constricted cordlike vessel and the resection of it serves to interrupt the constrictor reflex at the low level and releases the collateral circulation. This syndrome occurs most frequently following supracondylar fracture but may follow injuries of any kind and is likely to be frequent in the wounds of warfare.

The indications in these instances of sudden obstruction of the larger vessels are quite clear. In diseases producing gradual oblitera-

tion of the vascular bed they are not so readily determined. The most extreme of these is the arteriosclerosis common after the fifth decade. Too frequently this takes the form of cardiac, renal and cerebral disease, or to express it in another fashion is organal in its distribution. Among these is the pancreas, with diabetes mellitus. Material involvement of any or of a combination of these organs, usually means that the peripheral sclerosis is of secondary importance, and will not determine either the functional disability or the final outcome. Under these circumstances treatment to alleviate possible accompanying vasospasm is in most instances not worthwhile, particularly if it involves surgical procedures.

On the other hand, those instances of peripheral vascular sclerosis not so complicated, may have a considerable component of vasoconstrictor activity, responsible in part for intermittent claudication or for circulatory block leading to gangrene. Palpation and roentgenography of the large vessels and oscillometry will frequently indicate the extent of the organic disease, but the degree of vasoconstriction must be determined otherwise. This is best done by comparative temperature readings of the two extremities and their response to cooling or warming of the body elsewhere. To do this most satisfactorily, it is necessary to have thermocouples placed in series from the lower thigh to the toes, so as to obtain the gradient of the temperature, rather than isolated readings. Such an examination requires a special and somewhat costly apparatus which can be available in but few institutions. Short of this some idea of the presence or absence of vasospasm may be obtained by observing the flushing and paling of the skin under similar circumstances, or on change of position. Best of all are observations of this nature made under procaine block. Where the area in question is limited, the distal nerves supplying it such as the peroneal, the sural and the post-tibial may be directly injected, but where a more extensive involvement is to be studied, a paravertebral block is preferable. It is rarely justifiable to proceed with interruption of the sympathetic pathways, without such tests show promise of benefit.

Still another disease of the vessels in which the vasospasm may be an important component is the "thromboangiitis obliterans" of Buerger. Changes in the vessels precede this, but the deficient circulation and pain in many instances accentuate the functional disability to a degree that justifies interruption of the sympathetics, but not in the expectation of obtaining a cure, for this is a progressive disease in itself whatever the cause may be. The same methods of testing for the vasoconstrictive action are used as in arteriosclerosis, and the same criteria also for determining the indications for intervention. It must be emphasized, however, that particularly in Buerger's disease as Thompson[8] of our clinic has shown, thorough and regular toilet of the feet, with control of the epidermatophytosis, almost uniformly present and very probably the causative agent, will obviate the necessity of more drastic measures. So also the postural exercises so well described by Allen[9] will aid greatly in the development of a collateral circulation.

Perhaps closely allied to this thromboangiitis is the thrombophlebitis so common in the more superficial veins of the legs, and accompanied as Homans[1] has emphasized by lymphangiitis and an exudate edema extending along the great vessels in many instances into the pelvis. This is to be clearly distinguished from phlebothrombosis of the deep veins, which in pathology, treatment, and prognosis is entirely different, and gives rise to nearly if not all instances of massive pulmonary embolism. While reflex vasoconstriction seems to be no part of the latter, in the thrombophlebitis of the more superficial veins, Ochsner[10] has suggested that there is such an association and that paravertebral procaine block materially shortens the acute phase of the illness, and assists in the resolution of the process. This has not been sufficiently tried by others as yet to have been either accepted as a usual therapy, or to have been thrown into the discard. For those familiar with the technique of paravertebral injection it is worth a trial, keeping in mind that thrombophlebitis is a self-resolved and exceedingly variable disease, unpredictable in its course, and that therefore one may be misled as to the effectiveness of any remedy employed.

The treatment of these disorders discussed, so far as the sympathetic system is concerned, consists of interruption of the sympathetic arc, whether by mechanical or chemical means, and whether for a permanent or a temporary effect. This may be accomplished by block with procaine or alcohol, or by crushing the sensory nerves leading away from the area of irritative disease. Because of the anatomical distribution as sensory terminal divisions, the superficial and deep peroneal, the sural and the internal saphenous, may be so treated without interference with muscular function, and the posterior tibial at the level of the ankle likewise, for its motor function there is relatively unimportant. This local approach may be sufficient in many instances of circulatory disorders of the foot, but when the trouble is more extensive, interruption of the sympathetic by division of the preganglionic rami supplying the extremities, is preferable. This may be carried out temporarily by procaine block, or permanently by operative resection. While these procedures are not difficult and in skilled hands are accompanied by an extremely low morbidity and mortality, they should not be undertaken without detailed study of the anatomy involved and the methods in detail which have been developed.

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Most authoritative and valuable in any consideration of this subject are the monographs by Homans and by White and Smithwick. These have been brought up to date in excellent reviews by the same authors.

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2. Homans, John: Circulatory Diseases of the Extremities, 1939, Vascular Disorders of the Extremities. *New Eng. Jr. Medicine*, 1942, Vol. 226:917-922, 951-956.
3. Mulvihill, D. A., and Harvey, S. C.: The Mechanism of the Development of Collateral Circulation. *New Eng. Jr. Medicine*, 1931, Vol. 204, 1032-1034.
4. Gage, M.: Traumatic Injuries to the Peripheral Vessels in Both Civil and Military Practice. *Surgery*, 1942, Vol. 11, 983-986.
   Gage, M., and Ochsner, A.: Prevention of Ischaemic Gangrene Following Surgical Operations Upon Major Peripheral Arteries by Chemical Section of Cervicodorsal and Lumbar Sympathetics. *Ann. Surg.*, 1940, Vol. 112, 938-959.
5. Richards, R. L., and Learmonth, J. R.: Lumbar Sympathectomy in Treatment of Popliteal Aneurysm. *Lancet*, 1942, Vol. 1, 383-384.
6. Griffiths, D. L.: Volkmann's Ischaemic Contracture. *Brit. Jr. Surgery*, 1940, Vol. 28, 239-260.
7. Foisie, P. S.: Volkmann's Ischaemic Contracture. *New Eng. Jr. Medicine*, 1942, Vol. 226, 671-678.
8. Thompson, K. W.: The Relationship of the Dermatomycoses to Certain Peripheral Vascular Infections. *New Internat. Clinics*, 1941, Vol. 2, 156-170.
9. Allen, A. W.: The General Management of Circulatory Diseases of the Extremities. *New Eng. Jr. Medicine*, 1931, Vol. 204, 859.
10. Ochsner, A., and DeBakey, M.: The Rational Consideration of Peripheral Vascular Disease Based on Physiologic Principles. *J. A. M. A.*, 1939, Vol. 112, 230-236.

The rapid decline in tuberculosis mortality rates has been due mainly to lessening in the incidence of infection. Among those infected, the toll, though diminished, is still appalling. Mortality statistics, morbidity reports, autopsy examinations, tuberculin tests and X-ray surveys indicate that about half of all infected individuals develop clinical tuberculosis, and that from 10 to 20 per cent of them eventually die of the disease. The high risk of disease and death due to infection by the tubercle bacillus justifies increased efforts for its prevention.—Emil Bogen, M. D., *Amer. Rev. of Tuber.*, Aug., 1940.

Fulminating pulmonary tuberculosis, such as military tuberculosis is rather infrequent among persons in better circumstances, while fibroid phthisis is more likely to occur among persons under better economic surroundings. Extremely acute manifestations of rheumatic infections are relatively infrequent among the better-to-do, while the more chronic type of fibrosing mitral stenosis is more likely to occur. In both tuberculosis and rheumatic fever these differences are conditioned by better treatment, ability to obtain more rest, less arduous occupations and many other considerations.—O. F. Hedley, *Public Health Report*, October 11, 1940.

*The Portland Charitable Dispensary and The Portland Tuberculosis Class**

Thomas J. Burrage, M. D., Portland, Maine

At times it has been the custom of so-called orators at the annual meeting of the Portland Medical Club to review their past experiences in medical practice. Some of the excellent reminiscent articles which I can recall were presented by the late Drs. James Spalding and James O'Neil, and more recently by Dr. Owen Smith and Dr. Walter Tobey. At the request of our President, I am adding my bit of ancient history to what has already gone before. Dr. Welch suggested that I tell something of the Portland Tuberculosis Class which I organized in 1908, but because the history of this class comprised only three years, I also wish to discuss in addition the beginnings of the Portland Charitable Dispensary, which antedated the Tuberculosis Class by several years.

As there are no records of these ventures so far as I know, my historical observations may be somewhat inaccurate; but I think for this evening's purpose they are sufficient. It was in 1904 that I returned to Portland after an absence of ten years to begin the practice of medicine, and at the same time arrived Dr. F. P. Webster with a similar objective in mind. Along with us came a certain amount of Bostonian idealism and considerable training in the out-patient departments of Boston hospitals. We were well aware of the fact that most of the young physicians of that city worked long and hard in those institutions without remuneration, but with some valuable experience gleaned from long and gruelling hours of work. Naturally we had no practice, and little expectation of any for some time to come. After a year or so of this static existence, and without any offers of help from anybody, Dr. Webster and I, with the addition of Dr. Haskell and the late Dr. P. W. Davis, began to discuss the possibility of an out-patient clinic to be established in some section of the city where it was obvious we could develop such an institution. Looking to our elders in the medical profession, we asked opinion and advice from several. I need hardly add at this point that we not only received no encouragement in this venture, but were even advised to keep our hands off any such project, because free dispensaries and clinics undermined the morale of the poor and needy, and moreover took from certain physicians who did medical work for labor or fraternal organizations a certain part of their hard-earned living. Others said that there was no call for such a venture, since the city physician and city hospital took care of indigent cases. No encouraging note came from a single physician as far as I can recall. It was very evident that we would not only get no help from Portland physicians, but that we would on the contrary encounter open opposition. This certainly put us on the spot, but we decided to go ahead and at least make a trial of the free dispensary idea. The question of location naturally came first, and that of financial support second. After considerable scouting around the city where the more needy elements lived, we unanimously decided that the most likely location for patronage would be at the lower end of Middle Street. This was heartily opposed by several physicians, because they considered such a project was an intrusion into part of their practice territory. In spite of this, we persevered, and finally chose an upper rent over a grocery store on the corner of Middle and India Streets. These rooms were bare but well lighted, and the cleaning job, which was extensive, we did ourselves. A few articles of second-hand furniture as tables, chairs, etc., were sufficient for our initial purposes, and our medical and surgical equipment we carried in our bags. The clinic hours were from eleven to twelve A. M. on week days, and for the most part, all four members of the staff were present at that time. Drs. Davis and Haskell did the surgical work, while Webster and I attended the medical cases. A sign which proclaimed the presence of the Portland Charitable Dispensary was hung on the Middle Street side of the house above the

* Read before the annual meeting of the Portland Medical Club, Portland, Maine, December, 1942.

door and flight of stairs leading to the clinic rooms, and promptly attracted attention from our observing neighbors. Business opened up pretty well at first due to legitimate curiosity, but for some time thereafter it was variable, until our reputation as reliable practitioners of medicine became better established. Gradually our clientele increased, and, if I am correct, in about two years' time it was necessary for us to move into more commodious quarters.

Across India Street was a two and one-half story house in a moderate state of repair which had been our next objective for some time, and which after some financial dickering, we decided to take. We moved at once to these somewhat improved quarters, occupying only the lower floor at first. At about this time a young woman of the neighborhood, whose name I cannot remember, but who was much interested in the work of the Dispensary, became the official caretaker, telephone operator, emergency assistant, and general utility worker, and served with considerable efficiency until the final disposal of the project. Our medical and minor surgical work kept increasing, and before long it was necessary for us to take over the second story of the building as well, and an obstetrical clinic was started under the supervision of Dr. Davis.

At about this time the Bowdoin Medical School began to take cognizance of our existence, with a view to making use of our clinical material for teaching purposes. Our staff which had necessarily been increased, was sympathetic to this request, and from that time on until the closure, clinical teaching of sorts was provided.

As a side issue, I might say a few words about a competing out-patient clinic which was established at the Maine General Hospital at the request of Dr. Stephen Weeks, who became interested in our success, though he did not approve of our location or our facilities. He advocated the establishment of a clinic in one of the basement rooms of the Hospital, and requested that Dr. Tobey serve as surgeon, while Dr. Webster and I were to take care of medical cases. Dr. Weeks felt sure that the reputation of the Hospital would bring patients, and that the makeshift institution on India Street would soon die a natural death. We were game to this proposal and willing to compete with ourselves, feeling confident that location would prove the correctness of our ideas with regard to the strategic advantages of India Street. The hours of this new clinic were in the early morning so as not to conflict with the dispensary, but with the exception of a few patients, the venture was not patronized, and after about six months' trial, was abandoned.

You may ask how was the India Street dispensary financed, because in our heyday we had quite a clientele and a corresponding expense for rent, salary for the caretaker, supplies, heat, light and water. Our source of income was entirely from generous and charitably minded citizens of this city, and the work of securing funds devolved mostly on Dr. Davis and myself. It was a constant source of astonishment to me how some of the wealthy men and women of Portland handed over money for this venture often in fair amounts. How much our patrons actually knew about our work, and whether they ever visited the dispensary for inspection, I never knew, but at any rate, they continued their contributions yearly until the institution closed its doors. The end of the Portland Charitable Dispensary came with the building of the present structure just a few doors above our old quarters on India Street, but at least we had demonstrated the wisdom of our choice of locality. It was with considerable pleasure that we gave up the securing of necessary funds which were ever on the increase. Thus came to an end an experiment which had demonstrated its value, and which was superceded by a suitable structure still in active operation.

Let me now turn your attention to the Portland Tuberculosis Class, another stopgap institution which began its services in 1908, and continued for three years with considerable activity. The class idea started in Asheville, N. C., with the late Dr. Charles L. Minor, noted phthisiologist who began this method of treatment with his own private cases fifteen years before the method was used in other places for the care of indigent tubercular. In 1905, the first tuberculosis

class was established in Boston by Dr. Joseph Pratt, himself a cured victim of the disease, and in 1906, a suburban class was started at the Mass. Gen. Hospital under the direction of the late Dr. John B. Hawes. In 1908, the Rt. Rev. Robert Codman, at that time Episcopal Bishop of Maine, became interested in the class operated by Dr. Pratt for the Emmanuel Church in Boston, and contacted me through Dr. Weeks with regard to establishing a class in the basement of the newly erected chapel of St. Luke's Church of this City. Inasmuch as I knew both Drs. Pratt and Hawes, and had observed the operation of their classes, I felt that I was competent to organize and direct the new undertaking. Dr. Gehring became associated with me at once, and Dr. Welch soon afterward, while further help was secured from several fourth-year medical students. In those days, thirty-four years ago, the poor consumptive secured very desultory treatment from private physicians, and was allowed to proceed on his downward course with very little advice, discipline or encouragement. Was it any wonder then that he soon became depressed and careless, a burden to himself and his family, and a menace to all with whom he came in contact? In those days sanitaria were few, with only two in the State of Mass. and one in Maine at Hebron under the skilful supervision of Dr. Estes Nichols. Service charges in those institutions ran from four to five dollars a week in Rutland, and from twelve to fourteen a week in Hebron, a sum well beyond the reach of many tuberculosis cases. At that time, then, the tuberculosis class brought educational and disciplinary methods, which, although inadequate, at least had some value, and were distinctly better than nothing. The disadvantages easily apparent were limited control, less ideal surroundings, and poorer food.

The Portland Tuberculosis Class was very fortunate in being exceptionally well located and equipped in a large perfectly ventilated room in the newly built chapel of St. Luke's Church. Here, at weekly intervals, the class met with the physicians in charge, histories were taken, physical examinations made, and advice and instructions given to the patients. To maintain contact with the individual cases in their homes we had the services of a trained social service worker, who made calls, noted home conditions, food and care, and inspected the family and other contacts, reporting conditions to the physicians. Each patient kept a daily home record of his temperature, pulse and respiration, with notes as to his general feeling, appetite, cough, sputum, stomach and bowels. Beside the weekly meetings of the class, and the visits of the social service worker, we had a third and very valuable asset in our treatment, namely, a so-called day camp, located in East Deering, and operated for the five warm months of the year. The location of the camp, in an open space surrounded by woods, was ideal, and several rough shacks gave shelter in time of showers, housed the dining hall and kitchen, and served as storage room for the steamer chairs which the patients used for their outdoor rest treatment. With regard to the food which we gave our patients, we followed the plan used in the Mass. day camps, giving a substantial dinner at noon, supplemented by a lunch of bread and milk, or eggs and milk in the middle of the morning and afternoon.

What was the reaction of local physicians to the tuberculosis class? We soon found that it was viewed askance, and even with hostility, because the field of the family physician was being invaded. Our patients, therefore, did not come from physicians, but from the public direct, who had heard about our class and camp, and were eager to give us a chance when their lot otherwise seemed to be impossible.

The presence of the trained social service worker was one of our greatest assets, inasmuch as she had the supervision of the cases in the homes, and unearthed many developing cases in the families. In those days, X-ray examinations for pulmonary disease were rarely made, and reliance was placed on physical examination, the tuberculin skin test, the temperature record, and the sputum. With regard to the use of tuberculin, we began it as a diagnostic test in early cases, and later employed it for treatment in selected individuals, but soon came to the conclusion that it was not a safe method without closer supervision than was in our power, and so we abandoned its use.

Continued on page 188

The President's Page

To the Members of the Maine Medical Association:

Not only in our own Country, but also in Great Britain, Australia and Canada, Medical Practice Acts of various kinds are being proposed.

New Zealand passed a social security bill in 1938 which was found upon trial to be impractical, but in 1939 and 1941 improvements were made which included a "fee for service" scheme which is now in operation and although better in many respects than the original bill still offers no constructive policy for raising the standard of medical practice; and is retrogressive in that it has done nothing to abolish expressive pre-existing evils of medical organization and administration.

No medical practice act can be successful unless provisions are made for the coöperation of doctors in groups for mutual relief and better service. Provisions must also be made for postgraduate study and large scale research work in order that the general practitioner may be able to become familiar with the newer tendencies not only in diagnosis and treatment but also in preventative medicine and public health.

The Massachusetts Medical Society is sponsoring the "Blue Shield" and in order that we, The Maine Medical Association, may become better acquainted with its aims and purposes, Dr. James C. McCann of Worcester, President of the "Blue Shield" has been invited to address the Associations Council at its next meeting in October; Dr. McCann's remarks will be reported in entirety in the first publication of THE JOURNAL OF THE MAINE MEDICAL ASSOCIATION following the meeting.

OSCAR F. LARSON, M. D.,
President, Maine Medical Association.

Editorial

Armed Forces Must Have 6,000 More Physicians by January 1

Journal of A. M. A. Calls on the Profession to Fully Meet the Responsibility That Has Been Placed on It

The armed forces must have 6,000 additional physicians by Jan. 1, 1944, *The Journal of the American Medical Association* reports in an editorial in its August 7 issue. *The Journal* says:

"At a conference of the Directing Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians, held on July 31, with the War Participation Committee of the American Medical Association and in the presence of Mr. Paul V. McNutt, chairman of the War Manpower Commission and representatives of the Army and Navy medical departments and the Public Health Service, it became apparent that the medical profession must produce toward the winning of the war an additional six thousand physicians for the armed forces before Jan. 1, 1944. Pursuant to a realization of this objective a directive has gone to the generals in command of the various service commands authorizing them to induct into the service physicians between the ages of 38 and 45 who have been declared available by the Directing Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians and who are otherwise subject to Selective Service.

"The needs of the armed forces are real. The members of the War Participation Committee raised with the representatives of the various governmental agencies all the questions that have from time to time challenged the need; the challenge seems to have been met effectively. Indeed, the intimation was made clear that the needs of the armed forces will be met by specific regulations of the Selective Service Administration or the enactment of necessary legislation if required. All physicians up to 45 years of age who have been indicated as available have therefore placed on them now the responsibility for an immediate decision as to their enlistment with the armed forces. The need is so positive that questions of essentiality of men in positions of teaching and research and in industrial medicine are likely to be rigidly reviewed in the near future with a view to extracting from civilian life every one that can be spared.

"As the war continues and intensifies new needs for the services of the medical profession become apparent. An army in motion and one engaged in the kind of aggressive combat that now concerns our armed forces needs physicians in even greater numbers then have heretofore been demanded. Many thousands of interned aliens and prisoners are now the burden of the United States and must be given medical care.

"If there is any physician who stills hesitates under these circumstances, he should realize the added advantage to him of accepting now the commission that is proffered. Should it become necessary in the near future, as seems quite likely, to enlist new activity by the Selective Service Administration and the Officers' Procurement Service to bring in the six thousand physicians that are so certainly required, those recruited by that technic will inevitably begin their service with the minimum commission that is offered, namely that of first lieutenant. Until that technic is installed, the men of special competence and of years beyond those of the recent graduate have the assurance of careful consideration and a commission more nearly in accord with age and experience.

"The call here made has the approval of the Directing Board of the Procurement and Assignment Service and of the War Participation Committee of the American Medical Association. The medical profession may well be proud of the fact that it has been the only group given, by directive of the President, the responsibility of maintaining service in civilian life and at the same time supplying the needs of the armed forces. Let us not fail in meeting fully the trust that has been placed upon us."

Maternal and Child Welfare

Formulae

This article will deal with substances commouly used in infant feeding in an attempt to tell the physician what he can expect from varions foods. It is essential that the doctor have an idea why the infant is in difficulties, and what to expect when a change is made.

Dextri-maltose is a good carbohydrate for routine use in formulæ. It is less laxative than some of the others, and so is useful in fat indigestion and in convalescence from diarrhoea. It may be spit up more than some others, but it is doubtful if it causes skin rashes. Numbers one and two are essentially the same; number three is made more laxative by the addition of potassium carbonate. In dextri-maltose B an adequate daily intake of iron and vitamine B is added. Four level tablespoonfuls equal one ounce.

Milk sugar, the "natural" sugar is more laxative than dextri-maltose and so useful in constipated babies. It rarely causes spitting up. Beta lactose is more soluble and less "gassy." For older children it is useful to increase the caloric value of fruit juice and milk as it is not sweet. Three level tablespoonfuls equal one ounce.

Karo is heavier than the first two and so we use fewer tablespoonfuls. It is somewhat laxative. Its sweetness is a slight disadvantage. The white and brown forms are equally good and may be used interchangeably. Marriott was enthusiastic about this sugar and used it in large amounts, even up to ten per cent. This writer has never been able to use as much without producing diaarhoea, and so rarely prescribes over three tablespoonfuls in the day's mixture. Two tablespoonfuls equal one ounce.

Cane sugar is cheap and digestible. It has the disadvantage of accustoming the infant to sweet food but this is by no means a contraindication. Two level tablespoonfuls equal one ounce.

Mellins food is similar to dextri--maltose but lighter and more laxative. There are six level tablespoonfuls to the ounce.

Biolac is essentially evaporated milk with lactose. It has no advantage over a formula prescribed by the physician.

Olac is a dried milk with the fat in the form of olive oil. It is very good for infants who are unable to digest cow's milk, and for prematures. Use it in the proportion of one level tablespoonful to two ounces of water.

SMA and Similac are dried milk preparations with high fat content and high caloric value, containing cod liver oil. Watch out for fat indigestion, usually first manifested by loss of appetite, and for dehydration fever. Both are contraindicated in diarrhoea. Early loss of appetite is common. Use one level tablespoonful to each two ounces of water. Added cod liver oil is unnecessary but do not forget the orange juice.

Dryco is a dried milk food containing a low percentage of fat, moderate carbohydrate, and high protein. It is useful in certain cases of too frequent stools. The author uses it in the proportion of one level tablespoonful to each two ounces of water.

Dried lactic acid milk is a very valuable preparation, being easily digested and of high caloric value. It is very good especially when the baby can take only a small quantity at a time without vomiting, and will often work wonders in cases of marked malnutrition. The half-skimmed variety is often useful in stubborn cases of diarrhoea with malnutrition. Carbohydrate, usually Karo, should be added except in the kind which contains dextri-maltose. Put one level tablespoonful in each two ounces.

Casec is dried casein to be added to the formula. It is used for the treatment of fermental diarrhoea. One-third of an ounce in a quart of formula raises the protein one per cent. Half a teaspoonful in a half to one ounce of water before the feed is often useful in the case of the colicky, gassy breast-fed infant.

Your Committee on Maternal and Child Welfare.

Report of Committee on Social Hygiene Relative to the Venereal Disease Report Bill

The House of Delegates of the Maine Medical Association in session June 20th, at Augusta, following considerable discussion* relative to the Venereal Disease Report Bill passed at the last session of the Maine Legislature, voted "that this question be referred to the Committee on Social Hygiene, composed of Dr. Johnson (Oscar R.), Dr. Mitchell (Roscoe L.), and Dr. Blaisdell (Carl E.), ... and that the members of that Committee discuss this matter and make a report to the Council at its next meeting on their interpretation of the workability of the law, with the privilege and the request that this Committee consult our legal advisor in matters of interpretation." In accordance with this vote the Committee on Social Hygiene met and drew up the following report which was submitted to the Council at its annual summer meeting on August 1st, by Dr. Johnson, Committee Chairman, and which is self-explanatory.

You will note in the letter from LeRoy R. Folsom, Assistant Attorney General for the State of Maine, Counsel for the Department of Health and Welfare, to Herbert E. Locke, Esq., Counsel for the Maine Medical Association, which follows the committee report, that new forms are being printed, and that it is his opinion that "physicians who file the required reports in accordance with the requirements of the new forms and the instructions appearing thereon, will have performed their duty in a manner acceptable to the State Bureau of Health."

* See Proceedings, Second Meeting of the House of Delegates, June 20, 1943, page 185.

Report of Social Hygiene Committee

July 28, 1943.

A meeting of the Social Hygiene Committee of the Maine Medical Association was held July 20, 1943, at the office of the Director of Health at 7.00 P. M. Present were Doctor Oscar Johnson, Chairman, Doctor Carl Blaisdell, and Doctor Roscoe L. Mitchell. The chief topic of discussion was the law commonly known as the Venereal Disease Control Act passed at the recent session of the Legislature. Some helpful points concerning practices in venereal disease clinics were discussed.

It is recognized by all members of the committee that the venereal diseases are matters which may still not be handled as openly and freely as other communicable diseases are in Maine.

During the discussion it was brought out that there are certain requirements of the law under discussion as previously interpreted which in certain cases might prove a detriment to the service unless administrative procedures could be adopted which, while complying with the law, would allow some latitude in the matter of reporting certain patients to the State Bureau of Health. It was agreed that the Bureau is not in a position to change or ignore the statutes.

The following procedure was suggested to be put in practice subject to approval of the Attorney General's Department.

1. Clinic patients to be reported to the Bureau at Augusta on the Form V-11 by number, age, sex and color and at the same time a copy of the V-11 be made on Form V-16 (supplied by the Bureau) with the name and address and numbered to correspond with the V-11 number sent to Augusta, this copy to be kept at the clinic in a special file and available on request only to the Bureau Director, V-D Control Officer, and District Health Officer or his representative.

2. With reference to follow-up of cases or contacts by Bureau personnel it was recommended that in order to eliminate friction and embarrassing incidents in such follow-up that it is for the best interest of all concerned that no follow-up of cases or contacts of venereal diseases be made without first consulting the physician in charge of the case and that his advice be used as a basis for further action and conduct of the investigation.

3. The reporting of cases of physicians where free drugs are supplied by the Bureau may be made by number, age, sex and color in the same manner as other cases provided the record of name and address is available at the physician's office in case of need.

4. In case there is on the V-11 sent to the Bureau by physician a statement by the physician that examination of contacts has been done or arranged for, the case will be considered closed by the Bureau unless further report is had from the physician.

5. It was understood by the committee that all cases in which the service is to be paid for by the Bureau for individual service involving the rendering of a bill to the Bureau of Health reporting by name and address is essential.

Under a recent decision of the Attorney General's Department the above procedure would appear to be in compliance with the present law.

Roscoe L. Mitchell, M. D., *Director,*
Acting Secretary of the Committee.

RLM/jbr

August 10, 1943.

Herbert E. Locke, *Counsel,*
Maine Medical Association,
Augusta, Maine.

RE: P. L. 1943, Chapter 358,
Venereal Disease Report Bill.

Dear Brother Locke:

The form and content of the report or reports to be filed with the State Bureau of Health by physicians under the provisions of this law was thoroughly discussed with Dr. Mitchell a short time ago.

The State Bureau of Health under the direction of Dr. Mitchell is having new forms printed in compliance with our interpretation of the law. In my opinion, physicians who file the required reports in accordance with the requirements of the new forms and the instructions appearing thereon, will have performed their duty in a manner acceptable to the State Bureau of Health.

Very truly yours,

(signed) Leroy R. Folsom,
Assistant Attorney General.

LRF:ms
cc: Mr. Cowan
Dr. Mitchell

Necrologies

Owen Smith, M. D.,
1869-1943

Owen Smith, M. D., 74, died suddenly on July 30, 1943, at his Lakeland Farm, Sebago Lake, Maine. He retired from active practice about a year ago following a heart attack.

Born at Hiram, Maine, April 9, 1869, a son of William H. Smith, M. D., and Marcia Hodgton Smith, he received his early education in the schools of that town and at Fryeburg Academy. He was graduated from Bowdoin Medical School in 1892, and the following year was an interne at the Maine General Hospital. Post-graduate study at the University of Edinburgh and at the University of Vienna followed his internship. He was prominent in the profession, a specialist in Oto-Rhino--Laryngology, he served as surgeon at the Maine Eye and Ear Infirmary, the Maine General Hospital, and the Children's Hospital in Portland, and the Webber Hospital in Biddeford. He also served as acting assistant surgeon of the U. S. Navy.

Doctor Smith was a member of the Cumberland County Medical Association, the Maine Medical Association, the American Medical Association, the New England Otological, Rhinological and Laryngological Association, and the American College of Surgeons.

At the June, 1942, annual session of the Maine Medical Association he was presented with the Association's gold medal in recognition of fifty years in the practice of medicine.

He was much interested in agricultural and related circles, and was for many years secretary of the Portland Farmers Club, and served, for a long period, as president of the Maine Chamber of Commerce and Agricultural Society, retiring in October, 1938.

He is survived by a daughter, Miss Margaret Smith, a New York Attorney; and a son, Owen M. Smith of Portland. Mrs. Smith, the former Elizabeth Milliken of Portland, died twenty years ago.

Johnson L. Bean, M. D.,
1905-1943

Johnson L. Bean, M. D., 38, recently retired from the U. S. Army Air Corps, in which he served as a Captain, died suddenly at his home in Norway, Maine, on August 10, 1943.

A native of Jersey City, N. J., and a graduate of Tufts Medical College in 1933, he was an intern at the Maine General Hospital, Portland, before opening his office in Norway, nine years ago.

Doctor Bean enlisted in the Air Corps in August, 1942, and had been stationed at Miami, Florida, and in Colorado. He reopened his office in Norway on August 2, 1943.

He was a member of the Oxford County Medical Society, the Maine Medical Association, and the American Medical Association.

He is survived by his widow, Marie Bean; and his mother, Mrs. Margaret Nealy Bean of Catonsville, Maryland.

Harry W. Smith, M. D.,
1870-1943

Harry W. Smith, M. D., 73, practicing physician in Norridgewock, Maine, since 1902, died there on August 19, 1943.

Born at Hampden, Maine, May 1, 1870, a son of Sumner and Violetta P. Smith, he received his early education in the public schools of that town and at Hampden Academy. He was graduated from Dartmouth Medical College in 1900.

Doctor Smith served the towns of Smithfield, Larone, Rome, and Mercer as well as his home town. He was school physician of Norridgewock, and a member of the town advisory committee.

He was a member of the Somerset County Medical Society, the Maine Medical Association, and the American Medical Association. He was also a member of the Lebanon Lodge, F. and A. M., Cedar Chapter, O. E. S., and the Skowhegan Rotary Club.

He is survived by his widow, Grace Perkins Smith.

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Secretary, Allen H. Knapp, M. D., Calais

York
President, Arthur J. Stimpson, M. D., Kennebunk
Secretary, C. W. Kinghorn, M. D., Kittery

Notices

Medico-Legal Conference and Seminar in Legal Medicine

Sponsored by the Massachusetts Medico-Legal Society and the Department of Legal Medicine, Harvard Medical School

Medico-Legal Conference, October 6, 1943.

The Massachusetts Medico-Legal Society in conjunction with the Department of Legal Medicine of Harvard Medical School has arranged for an all-day Conference to be held at the Mallory Institute of Pathology, Boston City Hospital, on Wednesday, October 6, 1943. This will be open to any registered physician, lawyer, police official, criminal investigator, senior medical student or other person whose duties are associated with medico-legal topics.

It will include lectures, demonstrations, and informal discussions concerning many subjects in legal medicine, particularly stressing results of some more recent methods.

No limit has been made for the number of conference attendants, there is no fee, and advance application is not essential. Advance notice of intention to attend would be helpful, however, and should be addressed to Dr. William H. Watters, Department of Legal Medicine, Harvard Medical School, Boston.

Seminar in Legal Medicine, October 4 to 9, inclusive.

The Harvard Medical School, Courses for Graduates will offer a Seminar in Legal Medicine to occupy the entire week October 4 to 9, inclusive. It is planned particularly for medical examiners and coroners' physicians, but will be open also to any other suitable graduate of an approved medical school.

The course will be practical rather than theoretical and will consist of autopsy demonstrations, technique and interpretation of laboratory tests, study of the day-by-day cases of a medical examiner, round table conferences, and the many subjects now included in the widening field of legal medicine.

In order that each participant may receive the maximum benefit, the enrollment has been limited to fifteen. For the Seminar the fee is $25. Application should be made on or before October 1 to Harvard Medical School, Courses for Graduates, 25 Shattuck Street, Boston, Massachusetts.

Tufts Medical School Postgraduate Division

Postgraduate Courses for the General Practitioner

The courses announced below are designed for the busy general practitioner who wishes to bring his knowledge up to date. The work is largely given in the New England Medical Center (Boston Dispensary, Joseph H. Pratt Diagnostic Hospital, Boston Floating Hospital, and Tufts Medical School). Facilities of other hospitals in and around Boston are also available in several of the courses.

Fees: Tuition fees, as listed, are payable on the opening day of the course. In addition, the $5.00 registration fee covers all courses taken within a twelve-month period and is due upon acceptance for study. Checks should be made payable to the Trustees of Tufts College. The registration fee will be forfeited in cases of withdrawal without notification.

Fellowships: Through the Bingham Associates Fund, fellowships for post-graduate study are available for physicians practicing in Maine who are members of the Maine Medical Association. Application should be made to the Chairman. These fellowships are not available to physicians from other parts of New England; the tuition fees, however, are placed at a level calculated to make the courses available to the great body of physicians in New England.

CALENDAR

September: Electrocardiography (September 27-October 1) (Tuition fee $25.)

October: Internal Medicine (October 4-29) (Tuition fee $50.)
Allergy (October 18-22) (Tuition fee $25.)
Proctology I (October 25-30) Tuition fee $25.)

November: Proctology II (November 1-27) (Tuition fee $50. for two weeks; $100. for four weeks)
Endocrinology (November 8-12) Tuition fee $25.)
Hematology A (November 15-20) Tuition fee $25.)
Cardiology (November 15-20) (Tuition fee $25.)

December: Anesthesiology (November 29-December 2) (Tuition fee $25.)

January: Pediatrics (January 3-29) (Tuition fee $50.)
Radiology (January 10-13) (Tuition fee $25.)
Dermatology B (January 17-22) (Tuition fee $25.)
Diabetes (January 17-22) (Tuition fee $25.)
Advanced Electrocardiography (January 24-26) (Tuition fee $20.)

March: Diseases of the Bone and Joints (February 28-March 4) (Tuition fee $25.)

April: Proctology I (April 24-29) (Tuition fee $25.)

May: Internal Medicine (May 1-27) (Tuition fee $50.)
Proctology II (May 1-26) (Tuition fee $50. for two weeks; $100. for four weeks)
Surgery (May 1-13) (Tuition fee $150.)
Cardiology (May 1-5) (Tuition fee $25.)
Electrocardiography (May 8-12) (Tuition fee $25.)
Dermatology A (May 15-20) (Tuition fee $25.
Allergy (May 15-20) (Tuition fee $25.)
Endocrinology (May 22-26) (Tuition fee $25.)

July: Hematology C (July 3-15) (Tuition fee $75.)

(Note: All dates as given are inclusive.)

Courses in Cancer and Dietetics on request (minimum enrollment of four)

Ophthalmology — Monday, Wednesday, Friday mornings (Tuition fee $50.)

Otolaryngology — Morning course 9.30-12.00 (Tuition fee: five mornings a week, $50; three mornings a week, $30.)

Admission: Applications for admission should be made to the Chairman, Postgraduate Division, Tufts Medical School, 30 Bennet Street, Boston, Massachusetts.

Announcement of Graduate Teaching Service for the Army, Navy and Coast Guard

I. ORGANIZATION

The New England Committee for Wartime Graduate Medical Meetings represents the combined efforts of the state medical societies of New England and the National Committee for Wartime Graduate Medical Meetings sponsored by the American Medical Association, the American College of Physicians and the American College of Surgeons. The New England Committee consists of members of the original Wartime Graduate Committee of the Massachusetts Medical Society, representatives from other state medical societies in New England and the members of Districts 1 and 2 as appointed by the National Committee. Representatives of the First Service Command (Army), the First Naval District and the Coast Guard are also serving with this Committee.

The Committee realizes that many Army installations have received previous correspondence through channels relating to medical meetings. For the purpose of uniformity and despite a certain amount of duplication, this second communication is presented for your consideration with the approval of the First Service Command.

II. TYPES OF GRADUATE MEDICAL MEETINGS

The Committee offers the Army, Navy and Coast Guard installations three types of graduate medical instruction.

(a) The usual medical meeting with a program lasting an hour or two and covering a specific subject. Meetings of this kind may be planned for once or twice a month and include a wide range of subjects.

(b) A longer meeting, lasting through an afternoon and evening, with a program arranged to include one or more related subjects and presented by one or more visiting speakers. The afternoon to be devoted to ward rounds, symposium or discussion of clinical material and the evening session consisting of lectures or demonstrations. These meetings may be planned for once or twice a month.

(c) A three-day program: Wherever it is possible a three-day program may be presented. This longer program would cover material in any field of medicine that the officer personnel at the installation wish to have presented. Such programs would be presented by a group of instructors and

would include didactic lectures, demonstrations, ward rounds and round table discussions. Any request for this three-day type of program must be made through the headquarters of the First Service Command, the First Naval District, or the Coast Guard.

III. THE SMALL MEDICAL GROUPS

There are many service installations in New England where only a few medical officers are stationed. This Committee proposes that these posts too shall receive Graduate Medical Meetings if they wish but, whenever possible, these small groups should attend meetings at the larger installations nearby.

IV. REQUESTS FOR MEETINGS

In so far as it is possible, the Committee aims to give the type of service requested by individual installations. For programs (a) and (b) you should communicate directly with the Committee. If you have not submitted a list of subjects, please indicate your choices on the enclosed sheet.* If you have already sent a list through channels, it is copied on the back of the enclosed sheet; please check it for accuracy or make any changes you prefer.

Names of speakers and dates of meetings will be forwarded as soon as possible. Most of the civilian instructors are medical school teachers who have heavy schedules; it will require a few days to complete their assignments.

V. SPECIAL OR EMERGENCY REQUESTS

In the event that you have any special problems and wish assistance in the form of clinical discussions or medical consultations from recognized specialists, kindly call on the Committee at any time regardless of program commitments already made. Every attempt will be made to take care of such emergency requests promptly.

All correspondence relative to these Graduate Medical Meetings should be addressed to the New England Committee, 8 Fenway, Boston. It is planned to start the program in September, 1943.

* This sheet will be sent upon request to the New England Committee.

Proceedings

MAINE MEDICAL ASSOCIATION

House of Delegates

AUGUSTA, MAINE ❦ **JUNE 20, 1943**

Continued from the August Issue of the Journal, page 168

SECOND MEETING OF THE HOUSE OF DELEGATES, JUNE 20, 1943

The second meeting of the House of Delegates of the Maine Medical Association convened at the Augusta House, Augusta, Maine, on Sunday, June 20, 1943, at four-thirty o'clock in the afternoon, with Dr. Oscar F. Larson of Machias, Council Chairman, presiding.

CHAIRMAN LARSON: The meeting will please come to order. I am going to ask our Secretary to call the roll at this time. (Secretary Carter then called the roll and the following members responded.)

First District:

Cumberland County:—William Holt, M. D., Portland; Benjamin Zolov, M. D., Portland; Thomas A. Foster, M. D., Portland; Frank A. Smith, M. D., Westbrook. Alternate: Oscar R. Johnson, M. D., Portland.

York County:—James H. MacDonald, M. D., Kenenbunk.

Second District:

Androscoggin County:—Ralph A. Goodwin, M. D., Auburn; William H. Chaffers, M. D., Lewiston.

Franklin County:—George L. Pratt, M. D., Farmington.

Oxford County:—Harold W. Stanwood, M. D., Rumford.

Third District:

Knox County:—C. Harold Jameson, M. D., Rockland; James Carswell, M. D., Camden. Alternate: Abbott J. Fuller, M. D., Pemaquid.

Lincoln-Sagadahoc Counties:—James W. Laughlin, M. D., Newcastle. Alternate: Warren E. Kershner, M. D., Bath.

Fourth District:

Kennebec County:—Roland L. McKay, M. D., Augusta; Maurice Priest, M. D., Augusta.

Somerset County:—Walter S. Stinchfield, M. D., Skowhegan.

Waldo County:—Foster C. Small, M. D., Belfast.

Fifth District:

Hancock County: — Edward Thegen, M. D., Bucksport. Alternate: R. V. N. Bliss, M. D., Blue Hill.

Washington County:—Willard H. Bunker, M. D., Calais.

Sixth District:

Penobscot County:—Ernest T. Young, M. D., Millinocket; Frank D. Weymouth, M. D., Brewer; Samuel S. Silsby, M. D., Bangor; Leroy H. Smith, M. D., Winterport. Alternate: Forrest B. Ames, M. D., Bangor.

Piscataquis County:—Ralph C. Stuart, M. D., Guilford.

CHAIRMAN LARSON: The first order of business this afternoon is the report of the Nominating Committee by the Chairman of that Committee, Dr. William Holt.

DR. WILLIAM HOLT, Portland: Mr. Chairman, the Nominating Committee has made very little change from last year's nominations, owing to the war conditions and because of the absence of so many of our members.

(Dr. Holt then read the report of the Nominating Committee, as published in the July, 1943 issue of the JOURNAL, page 140.)

CHAIRMAN LARSON: What is your pleasure with reference to this report of the Nominating Committee?

A Member: I move the acceptance of this report.

This motion was duly seconded and was carried.

Chairman Larson: The next order of business is the election of Councilors from the Fifth and Sixth Districts. Nominations are now in order.

Dr. Ernest T. Young, Millinocket: I nominate Forrest B. Ames, of Bangor, as Councilor for the Sixth District.

Dr. Ralph C. Stuart, Guilford: I will second that motion.

Chairman Larson: Are there any other nominations for the Sixth District? If not, all those in favor will please signify in the usual manner. Those opposed?

The motion is carried.

Chairman Larson: Nominations are now in order for a Councilor for the Fifth District.

Dr. Edward Thegen, Bucksport: I nominate Dr. Bliss, of Blue Hill, as Councilor for the Fifth District.

This motion was duly seconded by Dr. Holt and was carried.

Chairman Larson: Under new business, we have the appointment of a presiding officer for 1943 and 1944, as Dr. Stephen Cobb, President-Elect, is now in military service.

Dr. Willard H. Bunker, Calais: Mr. Chairman and members of the Association. As I understand it, we are scheduled for a rather lean year, due to finances and military affairs. As Past President of the Association, I feel as though the affairs of this Association should not be left in the hands of some one unfamiliar with the management of this office. We have in our midst a gentleman from Washington County, I am glad to say, whom I have known for thirty-two years. I know his character; his standing in his community is beyond reproach. I have known him very intimately for many years and I know that he is familiar with the workings of this association, and I know that the association would be perfectly safe under his leadership.

At this time, it gives me much pleasure to nominate Oscar F. Larson as candidate for President of the Association.

This motion was duly seconded by several of the members present and was unanimously carried.

Chairman Larson: Is there any other new business to come before the meeting?

Dr. Oscar R. Johnson, Portland: Mr. Chairman and members of the Maine Medical Association. I have been requested by several of the Portland doctors to bring to your attention the recent legislation that relates to infectious and communicable diseases.

I realize that this law does not affect perhaps quite as much the individual physician as it does the doctors who are dealing with the clinics in Portland. But we feel that because of this law, there is a discrimination between the private and the clinic physician. If you will familiarize yourself with this law, you will notice that the clinic case requires the name, address, sex and color, whereas the private case only requires the age, sex and color.

We do not feel that this is a very democratic law, and any law, if it is going to be passed at all, should be equal to every one concerned.

We also feel that there has been a discrimination as to the different stages of the disease involved with each patient as they come to the clinic. As physicians who have dealt with the clinics for many years, who have given their time, we feel that our discretion as to the investigation of a particular case should be honored, and we don't believe that an individual who has reached the age of 50, 60 or 70 years of age who perhaps has had his infection for at least twenty to twenty-five years should be put on the same footing as a person who has newly acquired the disease.

Another thing about it is this. We have always been proud of the ethics of our medical profession, and we feel that the statement of the patient to the doctor should be secret, privileged, and kept inviolate.

I would appreciate it very much if we could have a short discussion at this time on this matter.

Chairman Larson: Does any one else have anything to say on the subject of this new law? There ought to be several here who are interested in that.

Dr. Benjamin Zolov, Portland: I don't think that very many of the physicians are aware of the fact that there is also a penalty that Dr. Johnson forgot to mention; in other words, if certain venereal diseases are not reported within 48 hours, there is a severe penalty imposed upon the physician who does not send in the case with a written diagnosis of the particular case.

Now, I think that any one who deals with a large number of venereal cases, both in clinics and in private practice as Dr. Johnson does, can readily see that if a patient realizes that his or her name is going to be sent in to Augusta for somebody's use now or in the future, the chances are they are going to seek information and treatment through physicians not capable of treatment and through other sources. There will probably be attempts made to get the sulfa drugs, that so many people know about, by other methods than through the reputable channels.

At the present time, I don't think very many of the physicians are aware of the seriousness of the law that was passed; it passed in such haste that when we did receive notification of the fact, it was just like a bomb shell in our midst. I understand there is going to be an emergency legislative hearing to be held sometime in the fall, and I think in fairness to those people whom we treat, whether they be private patients or those who are going to the clinic at the present time, it is only fair to give them what we call a deserved democratic type of treatment.

I feel that this Association should go on record in a democratic spirit and propose a measure to be brought up in the fall in an attempt to modify this law that was passed several months ago.

Dr. Thomas A. Foster, Portland: Mr. President, as I seem to be on the "left" side of the House, I will add to this discussion, which seems to have come from Cumberland County so far. It seems to me that any one who has read the law carefully must be impressed with the seriousness of the situation. I think that both Dr. Johnson and Dr. Zolov have said that we should follow the American procedure with reference to reporting a clinic patient, and the American procedure is violated when we report a clinic patient by name, age, color, address and sex, and when we do not report a private patient in that manner.

The law was passed in the interests of public health of course, in which we are all interested, and it was sponsored by the Department of Health, with which we are entirely satisfied.

However, it seems to me—and I am not dealing with venereal diseases at all and I rarely see them—that this is not the democratic way. I am a citizen of the State and a practitioner of medicine, and I have been opposed to the legislation as it was written, from the beginning, and I was very much surprised to see the compromise bill as it was passed. It seems to me that the bill defeats its own purpose.

I feel sure, as Dr. Johnson has said, that there are many ways of evading this law. I believe that the people who think they have some venereal

disease are going to have a certain pride about covering it up or a certain shame, and they are going to avoid consulting a physician; they are going to consult those who are not physicians; they are going to consult the quacks and other such people, and the diagnosis may be erroneous and the treatment may be erroneous, and the public health may suffer more than it benefits. It seems to me that the doctors are going to have some doubt about the diagnosis of patients, and they are going to have doubt legitimately, because it is difficult to make a positive diagnosis and sign your name to it. The diagnosis may be delayed. And, in reading over the law, which I hope you have all done and if you haven't, you should do so immediately because it is an extremely important piece of legislation, I believe that this Society ought to consider well some means of arranging some enforceable law that is going to be an honest-to-God law that can be properly enforced.

The law as it stands now puts a great burden on the practitioners of medicine. I think there is more than the practitioner of medicine involved here. The patient, the public health and the practitioner are involved. This law puts the burden entirely on the practitioners of medicine. If he doesn't fulfill the provisions of the law, he is subject to a heavy penalty.

I believe in protecting the public health. I think there are a good many laws on the books now which protect the public health. It seems to me there are laws that are sufficient to find out about these people who have contagious and infectious diseases who are not taking treatment, and that the Department of Health has a good deal of law now which they could enforce to protect the public health. It seems to me that this law is of doubtful value, and I should like to hear a discussion about it by some of the members, as Dr. Johnson and Dr. Zolov have requested, so that we may get an expression of opinion from the delegates here today.

Dr. Warren E. Kershner, Bath: I think that Dr. Mitchell will remember that I blew off steam about this same thing about ten years ago, when some politicians attempted to make the medical profession entirely responsible for the enforcement of the liquor law. I happened to be in a position at that time, as some of you will remember, to have something to say about it.

I think the same thing is true right now, the way this law is written, because it puts the whole thing on the medical profession. It doesn't allow sufficient time in many of these cases to make a diagnosis under anybody's system of diagnosis. We do not have the facilities for doing the blood analyses in every country town, and it takes time and it is impossible to do it in forty-eight hours. It seems to me that the whole thing is pernicious, because first, it is based on a threat, and then it is worked on the basis of that threat, and it is an absolutely unworkable law.

Dr. James A. Carswell, Camden: From my experience, which is very slight as far as venereal disease treatment is concerned, it has come to my attention that evasion as applied to this law is going to be much easier in the future than it was before, and it was very easy before. As a matter of fact, I happen to know that it is possible for a case of syphilis, after diagnosis and verification, not once but twice by the State Department of Health, upon being called in for treatment, refused treatment; the case was reported to the State Department of Health and the State Department of Health investigated the matter through the District Nurse who reported she was absolutely unable to get to first base, as far as getting that patient to a reputable physician for treatment.

Now, that has occurred not once, but more than once in my experience.

If the Department of Health or the enforcement agencies of the State are today not able to enforce the law requiring that the individual come under treatment, then I don't see how the present law is going to help out in any way, as far as controlling cases of venereal diseases is concerned.

I, for one, agree with Dr. Johnson and Dr. Zolov and Dr. Foster that some efforts should be made by this Association to bring about a change in the present law.

Dr. James H. MacDonald, Kennebunk: Too much publicity has been given to the public about the sulfa drugs, and there certainly will be plenty of evasion of legitimate treatment being taken by victims, because they know too much about the sulfa drugs and they will obtain them in some form or another and treat themselves to the detriment of their physical condition.

I think the law means well, but I think as the others have mentioned that there will be far more evasion under the law than there was before. And there was plenty of it before.

Dr. Foster: Mr. Chairman, to stimulate further discussion, I move that this question be referred to the Committee on Social Hygiene, composed of Dr. Johnson, Dr. Mitchell and Dr. Blaisdell, for a further discussion. That Committee has members of the profession practicing, and a member of the Department of Health. To repeat my motion, I move that this question (relative to the Infectious and Communicable Disease Law) be referred to the Committee on Social Hygiene, and that the members of that Committee discuss this matter and make a report to the Council at its next meeting on their interpretation of the workability of the law, with the privilege and the request that this Committee consult our legal advisor in matters of interpretation.

I believe this would give ample time to make any approach to the Legislature, or work out an arrangement with the Department of Public Health which would satisfy both the Department of Public Health and the physician and the patient.

Dr. Pratt: I will second that motion.

To be continued in the October Journal

The Portland Charitable Dispensary and The Portland Tuberculosis Class—Continued from page 176

The average attendance at the camp during these three years was fifteen patients, while the number in the class varied from twenty-five to thirty. In all, 298 persons applied for admission, but of these 193 were found to be actually tubercular, the majority of them being moderate advanced or far advanced cases. Only 16% of the 193 cases were pronounced arrested during their attendance in the class, the cause of this poor showing being poverty, ignorance, poor food and home conditions, with lack of discipline and control. You might ask what did it cost to run such a class and camp for a year, and who provided the funds for its support. The cost of maintenance for the first year was about $1800., the class with its paid social worker, the printing of our record books, necessary drugs and laboratory supplies took somewhat over half of this sum, while the remainder went to the equipment of the camp, food and street car tickets for the patients. The raising of the necessary funds for prosecuting our work was in the hands of a large committee appointed by Bishop Codman, and the various methods in vogue at that time were very successful. With each passing year, the cost of maintenance increased, as our ideas and plans grew, so that it was soon discovered that this was necessarily an expensive project.

At the end of three years, it was decided by the physicians and Board of Management, that because of the expense and the relatively unsatisfactory results of treatment, it was best to suspend this form of control, and rely on sanitorium treatment as the only practical way of dealing with indigent cases of pulmonary tuberculosis. Thus ended a venture which I believe was in keeping with the times, and at least served some educational value to the tubercular poor of this City, gave opportunity for a certain amount of teaching, and kept the City in line with methods of that day.

The Journal
of the
Maine Medical Association

Volume Thirty-four Portland, Maine, October, 1943 No. 10

*Cerebellar Astrocytoma—With a report of a Case in a 12-Year-Old Girl**

By T. Dennie Pratt, M. D., and A. H. McQuillan, M. D., Waterville, Maine

The latest statistical analyses in the literature indicate that of all the various types of intracranial tumors in children the most benign is the cerebellar astrocytoma. If this tumor is completely extirpated, the patient's chances for a permanent cure are close to 100%. Thus, every effort should be made to diagnose these tumors and have them removed by competent neuro-surgeons.

Astrocytomas are benign neoplasms occurring in the cerebrum and cerebellum, usually associated with single cysts. Grossly the margins of the new growth may appear indistinct. Histologically there is a variable proportion of cells and fibers, the former usually appearing fairly uniform in size and shape, possessing a moderate amount of cytoplasm about a vesicular nucleus. Calcium may be deposited within the tumor enough to be demonstrable at times in roentgenograms.

Among other cerebellar tumors are the rare astroblastomas, the malignant medulloblastomas, the ependymonas, and spongioblastomas. Still other lesions in the infratentorial space to be considered are the meningiomas and cerebello-pontile angle tumors.

Van Wagenen[1] was the first to point out (1934) that astrocytomas, which are found in the cerebellum of children, can be removed completely and that their prognosis is better than that of the meningiomas. Rarely, even without operation, persons with this type of tumor (astrocytoma) may survive for many years, as in the case of Hansman and Stevenson[2] in which the patient lived to the age of 41; at necropsy a cyst was found in the cerebellum with a mural nodule of an astrocytoma. In most instances, the cystic fluid is under increasing tension and must be evacuated. Cushing[3] relates the interesting case of O. M., Case 5, whose symptoms were relieved for 11 years by evacuating the cyst. Usually, however, the symptoms return much sooner and in order to give permanent relief it is necessary to remove the mural nodule.‡

* Presented at a joint meeting of the Somerset, Franklin, and Kennebec County Medical Societies, April 23, 1942, Waterville.

‡ Quoted from (5).

Davidoff,[4] who was Cushing's resident in 1925-26, recently (1940) wrote an article, in which he reported 12 cases of cerebral and cerebellar astrocytomas, of which 3 died in the hospital, the other 9 having had an average 5 year 2½ month survival time. Of these, 7 were cerebellar astrocytomas. Two died as a result of the operation. Of the remaining 5, one, a 35-year-old man, had merely a decompression and biopsy and died 14 months later. Another had the same procedure performed and lived for 11 years. The remaining 3 were still alive and well 13 to 14 years after their operations. Of the total number of 457 brain tumor cases seen from 1924-27, 170 were still living 7-14 years after their respective operations. All the patients with medulloblastoma died, only 1 surviving for as long as 5 years. Astroblastomas were uncommon, only 6 cases out of 152, only 1 still alive at the time of publication of the article.

One of the most outstanding contributions on cerebellar tumors has been the recent (1939) exhaustive monograph written by Bailey, Buchanan, and Buey[5] of Chicago. The basis for their study was 100 consecutive cases of brain tumor coming under their care.

Critical analysis was made in each case. These authors devoted 60 pages to the symptomatology of intracranial tumors and some of the conclusions on this subject are of particular interest. Vomiting occurred in 84 of their 100 cases and they state that this "is the most constant and one of the most important symptoms of tumor of the brain in children." It "usually does not differ from that induced from other causes. These cases are often diagnosed and treated for a surprisingly long period of time as 'cyclic' or 'psychic' vomiting, or as some gastro-intestinal disease, and, as a result, unnecessary appendectomies, tonsillectomies, and alterations in diet are frequently imposed upon these children. This error is probably the more common because for years textbooks and teachers have described the vomiting resulting from intracranial neoplasms as projectile, sudden in onset, not associated with nausea, and forceful. Although such vomiting may and does occur, it is not the most common.—It is usually associated with nausea which may be severe and persistent. There are, however, certain characteristics of the vomiting which are highly suggestive of its origin. The vomiting—tends to occur, particularly at the onset of the disease, early in the morning shortly after arising and before breakfast; later it may occur at any time. In general it is not related to the intake of food, although in not a few cases it has precipitated an attack. Usually, however, it is not followed by nausea; on the contrary, the child may be hungry and eat a full meal immediately after vomiting."

Grant, Webster, and Weinberger,[6] of the Hospital of the University of Pennsylvania, last year published an article in which they stressed that false localizing signs often may be caused by increased intracranial pressure and hydrocephalus; that is, alterations in visual acuity, convulsive states, and the Foster Kennedy syndrome. Of their cases 100 were female and only 58 male. The patients were predominantly in the lower age brackets: 50 cases in the 1-10-year-old group and 42 in the 11-20-year-old group. Papilledema was present in 126 cases and absent in 15; all of these were over 12 years of age, 3 were 13, and the others ranged from 20 to 41. In 9 patients who showed no papilledema, hydrocephalus was found either by ventriculography or necropsy. Lumbar puncture was done in 50 of their cases without any untoward effect; in 7 of these patients who had papilledema, the spinal fluid pressure was normal (100-200 mms. water). Nystagmus, often thought to be a common sign in cerebellar disease, was absent in 41 of their cases. Only ⅓ of 108 cases studied had roentgen-ray evidence of increased intracranial pressure. A supratentorial localization was made incorrectly in 5 patients. Two cases were diagnosed as having third ventricle tumors. The authors conclude that "the diagnosis of the presence of a tumor of the cerebellum presents few difficulties in the typical case. However, in the absence of characteristic neurologic signs, localization may be uncertain."

As a rule, the diagnosis of a cerebellar tumor is not difficult and can easily be made by obtaining a complete and accurate history and performing a thorough physical examination. Laboratory studies usually are only confirmatory in nature. The early symptoms, headache, vomiting, diminished vision, and

strabismus, almost always are due to the increased intracranial pressure and internal hydrocephalus. By virtue of their being confined to the infratentorial space, these tumors early, as a rule, rapidly effect partial obstruction of the Sylvian aqueduct. As for the cerebellar lesion itself the most significant symptom is ataxia, characterized by diminution, or loss, often homolateral, sometimes bilateral, of the ability to perform fine muscular movements. This may be easily demonstrated in a patient by having him walk, write, or perform rapidly alternating movements.

CASE REPORT

Fibrillary Astrocytoma in the Right Hemisphere of the Cerebellum

B. F. #10003, White, American female, aged 12.

This girl had been referred to one of us (A. H. M.) because of unexplained headaches and vomiting of 8 months' duration. At the onset of the present illness there had been some mild frontal headaches. Because of these the child was taken to a physician, who tested her eyes and prescribed glasses but without benefit. A month later she began to have vomiting with a minimum of nausea. Another physician was consulted who administered some medicine, but the symptoms persisted with increasing frequency. One month later the mother noted that the patient was a little awkward in her movements. Shortly thereafter she was seen by another physician who gave her a trial of vitamin B without benefit. About 1 month later the girl complained of not seeing well in school and had to be given a seat in the front row of the classroom. Eye glasses were tried with no apparent improvement in her vision. The child continued to attend school, however, and did tolerably well until 2 months before admission, when, because of the increased severity of her symptoms, she was kept at home. On February 16, 1942, she was admitted to the Thayer Hospital.

Past History: The child was believed to have had a normal birth. Subsequent development had been uneventful except for the usual childhood diseases without complications, up to the onset of the present illness. There had been no infections about the head or neck and no known exposure to tuberculosis or syphilis. She had stood well in her studies at school, and had been active in athletics.

Family History: Parents were living and well. Several siblings were in apparent good health. No known history of brain tumor, cancer, tuberculosis, or diabetes.

Physical Examination: T 99.2, P 112, R 22, B. P. 110/80. The patient was a pale, young, adolescent girl, of asthenic physique, who appeared moderately malnourished and evidently acutely ill. Although there was marked pallor of the skin, the conjunctiva and mucous membranes were of bright pink color. The muscles were generally hypotonic, particularly those of the right upper extremity. She lay quietly in bed during the examination, complaining occasionally of a moderately severe frontal headache. She was coöperative and oriented as to time, place, and person.

On getting the patient out of bed it was quickly discovered she could scarcely stand without wavering and lurching about. She could walk only a few feet unaided, taking her steps about 1 to 2 feet apart in attempting to improve her balance and holding on to the bed or chair to keep from falling. Most of the time her head was tilted to the left. There was no tendency to fall to either one side or the other. When the patient was asked to stand on one leg at a time, this instability was brought out even more dramatically, particularly when standing alone on the right leg.

Firm palpation and light percussion of the head evoked no tenderness. The pupils of the eyes were markedly dilated, but reacted normally to light and on accommodation. On looking straight ahead there was a constant, lateral nystagmus with the slow phase directed toward the right. On horizontal and vertical gaze, mystagmoid motions of the orbits were easily obtained.

Ophthalmoscopic examination (Dr. H. F. Hill) revealed edematous and hyperemic retinae and moderately choked discs (3 diopters). The latter had the fuzzy, hazy appear-

ance of a rapidly progressing new choking. The retinal veins were prominent and engorged, the arteries being barely visualized. Just to the right of both discs were 2 small, fresh hemorrhages. Visual fields showed no characteristic changes, only a slight contraction to color and form. Blind spots were enlarged, as might have been expected.

Otological examination (Dr. F. T. Hill) revealed no involvement of the cochlear or vestibular branches of the 8th cranial nerves, permitting us to feel we could rule out the rather remote possibility of a cerebello-pontile angle tumor.

Neurological Examination: Cerebral functions seemed to be unimpaired. However, there were several signs that pointed to the cerebellum as the source of trouble. There was a positive finger-to-nose test on the right and a questionable one on the left. Heel-to-knee tests were surprisingly fairly well performed. Adiadokokinesia was present in the right upper extremity while it was absent in the left. The right arm showed the "rebound phenomenon" which is considered by many neurologists to be almost pathognomonic of cerebellar dysfunction.††

Examination of the *cranial nerves* revealed: (1) moderate bilateral diminution in visual acuity; (2) ataxia of the ocular muscles, as demonstrated by the nystagmus; and (3) impairment of the ophthalmic branch of the 5th nerve, as indicated by absent corneal reflexes. Otherwise the cranial nerves were found to be functioning normally.

The patellar and Achilles *reflexes* were constantly absent; the abdominals were hyperactive and the plantars equivocal. The other deep and superficial reflexes were not unusual.

Laboratory Studies: Blood: R. B. C. 4,950,000. W. B. C. 9,300. Hgb. 95%. Differential: Polymorphonuclears 66, lymphocytes 30, monocytes 4. Smear not unusual. Hematocrit 45. Urine: straw-colored, 1.022, albumin 0, sugar 0, very rare W. B. C., no R. B. C. or casts. Corrected sedimentation rate 25.5 (Cutler method). Blood Hinton negative. Tuberculin (patch) test negative.

Stereoroentgenograms of the skull (Dr. M. Lubell) were reported as follows: "Lateral stereo and occipital films show marked digital impressions on cranial wall with thinning of the skull and widening of the sutures. These signs are indicative of increased intracranial pressure. The sella is not enlarged. There is apparently some decalcification of the posterior clinoid process. No calcification intracranially. No localized area of bone destruction." Chest films were negative.

Lumbar puncture was not done as we felt that this procedure was not entirely devoid of danger, particularly so in a person who presented as much evidence of increased intracranial pressure as this patient did.

It was our impression that this girl probably had a neoplasm in the right hemisphere of the cerebellum. While frontal lobe tumor, cerebellar abscess, tuberculoma, and gumma had been considered, we felt they could with reasonable justification be ruled out.

Hospital Course: During the first part of her stay, the patient improved symptomatically, and for the first 2 days had no headache or vomiting. In view of our diagnosis we felt that the patient should have the benefit of an exploratory craniotomy. While awaiting transfer to the Neurosurgical Service of Dr. Donald Munro at the Boston City Hospital, the patient was allowed to return home, but increasing frontal headaches and vomiting necessitated readmission to our hospital. Fifty per cent glucose in 200 cc. amounts was administered intravenously without noticeable improvement. At times, brief tonic convulsions were observed by the nurse in charge.

†† The "rebound phenomenon" can be easily demonstrated by the following test: The person who is being examined is asked to flex his arm, while the examiner grasps the patient's wrist and attempts to pull the arm toward himself; suddenly the examiner lets the arm go; in the normal person the forearm flexes sharply but is stopped by the antagonistic muscle groups coming into play; in the person with cerebellar disease, the forearm continues to flex itself on the upper arm, the hand sometimes striking the patient's own face or shoulder forcibly. This phenomenon can be demonstrated by means of another test: In persons who have this "cerebellar ataxia," when given a glass of water to hold in their hand, there is an exaggerated extension of the fingers just before the glass is about to be grasped; this phenomenon also again occurs after the glass has been unclasped.

On March 9th, 4 days after transfer to the Boston City Hospital, a bilateral suboccipital craniotomy under Pentothal Sodium anesthesia was performed by Dr. Munro. During preparation of the scalp, the patient suddenly became cyanotic and apneic, requiring artificial respiration aided by O_2 and CO_2 inhalations under pressure. Upon removal of the bone flap, the dura appeared tense and hyperemic. Reflecting the latter an enlarged, bulging right cerebellar hemisphere was seen. This was definitely fluctuant, and about 5 ccs. of clear, straw-colored fluid was aspirated. Incision was then made diagonally across the right hemisphere and a large thin-walled cyst found. Further exploration revealed the presence of adjacent neoplastic tissue, part of which was found to have involved a portion of the cyst wall. Removal of the tumor tissue necessitated the resection of about 75% of the right hemisphere. In closure, the dura was left open, the bone flap replaced, and the scalp sutured tightly without drainage. One transfusion was given during the the operation and 2 others after the patient had returned to her bed. Pathological report (Dr. Frederic Parker, Jr.) of the tissue removed was "fibrillary astrocytoma."

Convalescence was uneventful, the wound healed per primam, and the patient returned to her home 4 weeks later. Her improvement since has been steadily progressive. She has had no headaches or vomiting and she can get about by herself, showing surprisingly little ataxia. She is gaining rapidly in weight and in strength. Prognosis by this time can be said to be excellent, and with considerable justification, we can hope for a permanent and complete cure.

Conclusions

(1) Cerebellar astrocytomas are the most benign intracranial neoplasm found in children. Complete removal offers an excellent prognosis.

(2) Diagnosis is not usually difficult if a careful history, physical examination, and complete neurological examination are carried out. Too often significant signs and symptoms are overlooked or wrongly interpreted.

(3) A case, in a 12-year-old child with recovery, is reported.

Addendum

Since this paper was written the patient has been seen several times, the last on June 5th. She has continued to do well. She plays tennis, reads assiduously with no known impairment of vision. Finger-to-nose and heel-to-knee tests are performed normally; patellar and ankle reflexes are also normal.

The authors wish to express their thanks to Dr. F. T. Hill for his helpful and constructive criticisms in the writing of this paper.

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The risk of contracting tuberculosis from extra-familial contact is greatest among school companions at the ages when resistance to the disease is lowest, namely, the "teen" ages, and among fellow workers, especially when the occupation is one which increases the risk of developing affections of the lungs. —*Report, Milbank Mem. Fund,* 1928-40.

Wartime Nursing Is Different

It is utterly impossible to provide the necessary volume of wartime nursing service on a peacetime basis. Places where nursing is going on as usual must share with others. Individual nurses who have not made adjustments to wartime needs for their service should understand the necessity for their participation.

The National Nursing Council has pointed out that the value of any national plan must be judged by its usefulness at the local level, i.e., where nurses live and work — in the country, in the villages, towns, and cities of the nation.

Wartime nursing is different! That inescapable fact must be generally accepted by nurses, by physicians, and by hospital administrators. Energy and motion now spent in resistance to change must be released for the attack on war-created needs.

Nurses have wrought many changes, but not enough, in the pattern of nursing service since Pearl Harbor. "We just do the best we can" is heard more frequently than "This is our plan." Generally speaking, educational programs have received more thought than the service programs. Acceleration of the basic course in nursing is an outstanding example. State boards of nurse examiners have initiated others.

The principles of good nursing have not changed, but nurses are learning to concentrate on the essentials. In the analysis and administration of nursing service radical changes are being made. Tremendously valuable assistance in caring for patients is being secured from the Red Cross nurse's aides and other volunteers as well as from paid auxiliary workers.

Thus far nursing service has not been rationed; such rationing would be complicated by the differences in individual nurses and the degree of essentiality of needed services. The sharing of services is more difficult than the sharing of goods.

A critical shortage of nurses exists. Here are the facts:

Over 36,000 nurses are now with the armed forces and the Red Cross has accepted responsibility for the recruitment of an equal number by June 30, 1944. Our men are receiving skilled medical care of a high order as shown by the high percentage of recovery from injury. Skilled nursing is an important factor in such care. Then, too, the very presence of nurses near the bases of military operations has repeatedly been described as a potent force in maintaining morale.

There has been an unprecedented increase in the use of civilian hospitals. Hospitals gave fourteen and a quarter million more days of care in 1942 than in the preceding year and the trend still is definitely upward. This is in keeping with the rapid growth of the Blue Cross (group hospitalization) plans and the Children's Bureau hospitalization program for the care of the families of service men.

Nursing is essential to the nation's health. The National Nursing Inventories (of nursing resources) of 1941 and 1943, by the U. S. Public Health Service, offer a comparison of data for the two years.

The total number of nurses graduated in the two years is well in excess of the number withdrawn for military service; this fact is not apparent in the inventory. The returns are apparently incomplete. Active nurses who did not return their questionnaires apparently did not realize the profound importance of the information requested. This information is the basis for present planning and safeguarding the future.

The relatively small decrease in the number of institutional nurses is much less significant than the increased use of hospitals in creating the serious shortage of nurses. The increased number of nurses in industrial nursing is, of course, not surprising.

The large number of inactive nurses who reported themselves available is encouraging, but — available for what? Full time? Part time? These nurses and others who are still "hidden" can make a valuable contribution to

our nursing resources. Although it requires a little more planning, the service of two part-time nurses can equal that of one full-time one. Wartime nursing puts a tremendous burden on all the administrative nurses.

Here is the program of the new Nursing Division of the Procurement and Assignment Service. The Red Cross recruitment committees are pledged to recruit 36,000 nurses this year. The new division will (1) determine the availability for military service or essentiality for civilian service of all nurses eligible for military service and submit such determinations to the American Red Cross for use in procurement of nurses for the Armed Forces; (2) promote plans for maximum utilization of full-time nurses and those who are able to serve only part time; (3) develop and maintain a roster of all graduate registered nurses, and (4) develop and encourage sound methods of supplementing the work of nurses with non-professional personnel.

National Nursing Inventories

	1941	*1943*
Total returns	289,286	259,174
Active		
Institutional	81,708	77,704
Public Health	17,766	18,900
Industrial	5,512	11,220
Private duty	46,793	44,299
Other	21,276	18,476
Inactive but available for nursing	25,252	38,746 (of these 23,576 are married and under 40)
Inactive, not available	90,979	49,829
In Nurse Corps of Army and Navy	6,371	over 36,000 (precise data not available)

Through the War Manpower Commission, nursing will not only have the benefit of the experience of medicine in the procurement and assignment of physicians, but means will be found to interpret wartime nursing to physicians and their coöperation secured in effecting desirable wartime adjustments.

Suggested Reading

1. *Priorities for Nurses.* National Nursing Council for War Service, 1790 Broadway, New York, N. Y. May, 1943, revised edition.

2. *Distribution of Nursing Service During War.* National Nursing Council for War Service, 1790 Broadway, New York, N. Y. May, 1942.

3. *Volunteers in Health, Medical Care and Nursing.* U. S. Office of Civilian Defense, Washington, D. C.

The President's Page

To the Members of the Maine Medical Association:

The present session of Congress will probably study the so-called Wagner-Murray Bill very carefully, and we hope with an open mind. That portion of it entitled "Federal Medical Hospitalization and Related Benefits," concerns all of us individually and collectively.

The September twenty-fifth edition of the *Saturday Evening Post* has an editorial entitled "Do we need Federal Medicine?", from which I quote: "From the ambitious nature of the scheme one might conclude that American medicine had never done anything for the indigent and that the one thing necessary to guarantee good health to all, is the creation of a vast scheme for State Medicine with more billions to spend than was considered necessary to run the whole country fifteen years ago. Although organized medicine as represented by A. M. A. Bureaucracy has often failed to respond to the demand for wider distribution of Medical Care, the actual history of American Medicine, though, is a constant record of expanded service, scientific advance and social responsibility. All the way from the country doctor, who needs no Federal Salary to get him out at 3 A. M. on a baby case, to group medicine like the Blue Cross Hospital payment plan, American Medicine is trying to meet the health needs of the country."

It is difficult for many of us to see the need of Federal supervision of our every day work. The question is whether the needs of the people who lack adequate medical care cannot be taken care of at a social cost lower than can be done by the coördination of all Medical service under Government jurisdiction.

Federal support may be needed in formulating and directing some phases of our work. A Natural Evolution, slow growing and carefully undertaken, is much better than some Radical Miracle full of political promise, but meager performance.

Let us all keep abreast of this movement which threatens to change our entire mode of life. I wish to remind you to carefully study your copy of Senate Bill S. 1161.

Fraternally yours,

Oscar F. Larson, M. D.,
President, Maine Medical Association.

Editorials

Medical and Public Opinion Mounting Against Health Bill

Journal Says This Indicates An Awareness of the Tremendous Stakes They Have in Wagner-Murray-Dingell Measure

During the past two months there has been a mustering of medical and public opinion against the Wagner-Murray-Dingell bill which indicates an awareness by the medical profession and the public of the tremendous stake that they have in this legislation, *The Journal of the American Medical Association* for September 4 points out. *The Journal* calls for unity in the medical profession in the attack on the technic for rendering medical service proposed by this legislation. *The Journal* says:

"Hearings on the Wagner-Murray-Dingell bill, which was fully analyzed by the Bureau of Legal Medicine and Legislation of the American Medical Association and commented on editorially in *The Journal,* June 26, will no doubt be held in the near future, probably after Congress has completed the new tax bill. According to the *United States News,* advocates of the expansion program for social security assert that it has caught the popular fancy, that pressure for its adoption is increasing daily, that the plan is a big step toward one of the Four Freedoms of the Atlantic Charter — Freedom from Want — and that Congress would face a storm of public criticism if it failed to approve the main provisions of the plan. On the other hand, opponents assert that the program would constitute a capital levy of ruinous magnitude on United States business, that even with the 12 per cent payroll tax the plan would be underfinanced, and that, should Congress enact such a bill, a dominant bureaucracy would be created which would end free enterprise in the United States and alter the whole way of American life.

"The editorial published in *The Journal* on June 26 emphasized that this bill is an evolution of the National Health Conference of 1937. It pointed out further that the measure was prepared without consultation with the medical profession, that it would make the Surgeon General of the United States Public Health Service a virtual 'gauleiter' of American medicine and that it would be, in fact, the acme of bureaucratic control of medical service. In the two months that have passed there has been a mustering of medical and public opinion against this measure, indicating awareness by the medical profession and the public of the tremendous stake that they have in this legislation. The editor of the McKeesport (Pa.) *Daily News* states the case succinctly:

> It would place the doctors under political control and provide for the mass of the people physicians who are politically amenable rather than those with superior abilities and skills. And would deaden one of the most highly regarded professions the world has ever known. . . . Success of bill 1161 and the destruction of the freedom of American medicine would be the come-on for other broader, more revolutionary schemes to circumscribe the American people.

"The periodical *America* says, in a statement by one of its editors:

> Now, will public regimentation of health servants operate to preserve the profession and thus ultimately help to preserve the body politic? It seems that such action—as, for example, that contemplated in Senate bill 1161—would create a new class of political doctors. And in America political classes are commonly subject to the influence of political practice, in seeking emoluments and avoiding burdens, unless we take the rare case of the unusually elevated individual. The system as it works does not raise personal ideals. But doctors without high personal ideals are a menace, both to the patient and to the public.

"An editorial in the Middletown (Ohio) *News Signal* says:

> The Wagner bill will be considerably modified, but some of its worst features may become law unless it is seen in its true light. It is part of a program, now well advanced, to enslave the individual to the state. In this process he gradually loses his adult self reliance, lapses toward infancy and then degenerates into a willing slave of government.

"The Charleston (S. C.) *News-Courier,* in a sarcastic editorial contribution, emphasizes the political aspects of this measure. It suggests that the medical administrators under the Wagner-Murray-Dingell bill be elected by popular ballot. The medical administrator would have the right to appoint the doctors and assign the cases. He could expect the support of the doctors that he appointed to help him get reelected, and the doctors would use their automobiles and C cards to help haul voters to the polls. They could also contribute to a fund to buy radio time for campaign speakers. Any doctor who worked against the medical director's reelection might find it difficult afterward to practice. Appointments in the medical colleges would, of course, be handled like other political patronages so that deserving party members could have their sons trained free of charge. Incidentally, it is pointed out, a lot of useful confidential information could be picked up by the doctors on their rounds that would help the party to stay in office.

"And the Jackson (Tenn.) *Sun* comments metaphorically:

> We are indeed a sick nation if we are willing to swallow such a pill. After swallowing it we would find that, instead of taking a progressive stimulant, we had taken a political opiate intended to dull our senses. . . .

"The editor of the Buffalo *News* suggests that the proposed measure provides for a set-up 'closely approaching that in the totalitarian nations.' He urges, furthermore, that the people, if they have put upon them the full measure of social security proposed by the New York senator, 'soon would be in a condition to yield themselves up as wards of the state.'

"At its meeting held in Chicago on August 26, the American Bar Association gave its approval to a resolution opposing any legislation now before Congress which 'seeks to establish federal control of the medical profession and the regimentation of doctors and hospitals.'

"The periodical *Medical Care,* edited by Mr. Michael Davis, suggests that the Wagner-Murray-Dingell bill was introduced on the demand of organized labor for the expansion of social security and that the timing may be accounted for by the probability that realists who are pushing this bill are more hopeful of dramatizing an issue for 1944 than of congressional action this year. The editorial indicates, incidentally, that the bill goes beyond the plans put forth by the President and the Social Security Board.

"In his editorial Mr. Michael Davis suggests that American physicians can now be divided into three groups: those who support the policies of the American Medical Association, those who differ with them but who keep silent and those who differ and say so publicly. Mr. Davis takes great encouragement from the statement recently released by Drs. John Peters, Channing Frothingham and others which apparently indicates to him a division in the medical profession and a gathering of strength against the policies of the American Medical Association.

"Already an announcement has been made in the press that Senators Wagner and Murray propose to have early hearings on this measure. Certainly the Board of Trustees and the newly established Council on Medical Service and Public Relations will give early consideration to the manner in which the American Medical Association is to be efficiently represented in the proposed hearings.

"Regardless of any other considerations on which there might be a difference of opinion among the vast majority of physicians of the United States, unity is demanded in the attack on the technic for rendering medical service proposed by the Wagner-Murray-Dingell bill. Senator Wagner in his public statement said 'I do not claim this bill is in any sense a perfect instrument; it is offered simply as a basis for legislative study and consideration.' Let us take the Senator at his word and prove to him and his colleagues, by a complete and forceful presentation of the points of view of American medicine, how far from perfect is the measure that he has proposed."

The Wagner-Murray-Dingell Social Security Plan

An Analysis Prepared by the Bureau of Legal Medicine and Legislation, American Medical Association

Reprinted from The Journal of the American Medical Association, June 26, 1943.

Referred to generally as embodying an Americanized Beveridge plan but offered in Congress, according to Senator Wagner, "simply as a basis for legislative study and consideration," legislation was introduced, June 3, in the Senate by Senator Wagner, New York, for himself and Senator Murray, Montana, and in the House by Representative Dingell, Michigan, proposing to create a Unified National Social Insurance System (S. 1161; H. R. 2861). The Senate bill is pending in the Senate Committee on Finance and the House bill in the House Committee on Ways and Means.

The system proposed to be created will be financed in general from a trust fund established by a 6 per cent employee and a 6 per cent employer contribution on all wages and salaries, up to the first $3,000 a year, paid or received after Dec. 31, 1943. Included in this proposed system will be a system of public employment offices, increased old age and survivors' insurance benefits, temporary and permanent disability insurance benefits, protection to individuals in the military service, increased unemployment insurance benefits under a federalized unemployment system, maternity benefits, medical and hospitalization insurance benefits, a broadening of the basis of the existing social security program to embrace some 15,000,000 persons now excluded, such as farm workers and domestic servants, employees of nonprofit institutions, independent farmers, members of the professions and other self-employed individuals, and a unified public assistance program. There follows an analysis of those provisions of the ninety page bill that appear to be of particular concern to medicine.

Disability Benefits Plus Medical Care

The bill broadens the existing social security coverage by providing for the payment of cash permanent disability benefits to beneficiaries. In addition to such cash benefits, the Social Security Board, through the Surgeon General of the Public Health Service, will be authorized to make provision for furnishing medical, surgical, institutional, rehabilitation or other services to disabled individuals entitled to receive insurance benefits, if such services will aid in enabling such individuals to return to gainful work. Such services, it is contemplated, will be furnished "by qualified practitioners and through governmental and nongovernmental hospitals and other institutions qualified to furnish such services." In administering the provisions of this particular section of the bill, the Surgeon General and the Social Security Board will follow as far as applicable the procedure outlined by another section of the bill relating to medical, hospitalization and related benefits generally.

Medical, Hospitalization and Related Benefits in General

Section 11 of the bill proposes to add a new title to the Social Security Act, title IX, providing for a federal system of compulsory medical and hospitalization insurance for all persons covered under the old age and survivors' insurance, and their dependents. Each insured worker and his dependent wife and children will be entitled to receive general medical, special medical, laboratory and hospitalization benefits. In addition, the system is made elastic so that it may be enlarged in its coverage to admit other beneficiaries on a voluntary basis, such as self-employed individuals and employees of states and political subdivisions.

In order to appreciate the broad scope of this new title, consideration must initially be given to the meaning of the words and phrases used in it. The term "general medical benefit" means services furnished by a legally qualified physician, including all necessary services such as can be furnished by a physician engaged in the general practice of medicine, at the office, home, hospital or elsewhere, including preventive, diagnostic and therapeutic treatment and care, and periodic physical examinations.

The term "special medical benefit" means necessary services requiring special skill or experience, furnished at the office, home, hospital or elsewhere by a legally qualified physician who is a specialist with respect to the class of service furnished.

The term "laboratory benefit" means such necessary laboratory or related services, supplies or commodities, not provided to a hospitalized patient and not included as a part of the general or special medical benefit, as the Surgeon General of the United States Public Health Service may determine, including chemical, bacteriologic, pathologic, diagnostic and therapeutic x-ray and related laboratory services, physical therapy, special appliances prescribed by a physician, and eye glasses prescribed by a physician "or other legally qualified practitioner."

The term "hospitalization benefit" means (1) not less than $3 and not more than $6 for each day of hospitalization, not in excess of thirty days, which an individual has had in a period of hospitalization; (2) not less than $1.50 and not more than $4 for each day of hospitalization in excess of thirty in a period of hospitalization; and (3) not less than $1.50 and not more than $3 for each day of care in an institution for the care of persons suffering from chronic ailments. The exact amount of the benefit, between the minimums and maximums stated, will be fixed by the Surgeon General of the Public Health Service after consultation with the National Advisory Medical and Hospital Council to be created by the bill and after approval by the Social Security Board. In lieu of such compensation, the Surgeon General may, after approval of the Social Security Board, enter into contracts with participating hospitals for the payment of the reasonable cost of hospital service, at rates for each day of hospitalization neither less than the minimum nor more than the maximum applicable rates previously mentioned. Such payments will constitute full reimbursement, the bill provides, for the cost of essential hospital services, including the use of

ward or "other least expensive facilities compatible with the proper care of the patient."

Panel of Physicians to Supply Medical Care

The Surgeon General will be required to publish and otherwise make known in each area to individuals entitled to benefits the names of general practitioners who have signified their willingness or desire to participate in the insurance program. Any legally qualified physician may so participate. A beneficiary may select any physician appearing on the panel to treat him subject to the consent of the physician selected, and may change such selection in accordance with such rules and regulations as may be prescribed. The Surgeon General may set maximum limits to the number of potential beneficiaries for whom a general practitioner may undertake to furnish medical benefits. Such limits may be nationally uniform or may be adapted to take account of "relevant factors."

The services of specialists will ordinarily be available only on the advice of the general practitioner. The Surgeon General will determine what constitutes specialist services and will also determine the qualifications of physicians as specialists "in accordance with general standards previously prescribed by him after consultation with the council and utilizing standards and certifications developed by competent professional agencies."

Payments for the Services of Physicians

Payments to general practitioners may be made (1) on the basis of fees for services rendered, according to a fee schedule approved by the Surgeon General; or (2) on a per capita basis, the amount being according to the number of individuals entitled to benefits who are on the practitioner's list; or (3) on a salary basis, whole or part time; or (4) on a combination or modification of these bases. The method of payment, subject to the approval of the Surgeon General, will apparently be determined in each area in accordance with the desires of a majority of the general practitioners collaborating with the insurance program.

Payments to designated specialists may include payments on salary (whole or part time), "per session," fee for service, per capita, or other basis, or combinations thereof. Apparently the method of payment to be adopted for specialists will be determined by the Surgeon General.

Payments for medical services may be nationally uniform or may be adapted to take account of "relevant factors." In any area where payment for the services of a general practitioner is on a per capita basis, the bill provides that the Surgeon General shall distribute on a pro rata basis among the practitioners of the area on the panel those individuals in the area who, after due notice, have failed to select a general practitioner or who, having made a selection, have been refused by the practitioner.

The bill provides that in each area the provision of general medical benefit for all individuals entitled to receive such benefit "shall be a collective responsibility of all qualified general practitioners in the area who have undertaken to furnish such benefit."

Limitations on General Medical and Laboratory Benefit

The Surgeon General and the Social Security Board may determine for any calendar year or part thereof that every individual entitled to general medical benefit may be required by the physician attending him to pay a fee with respect to the first service or with respect to each service in a "spell of sickness" or course of treatment if it is believed that such a determination is necessary and desirable to prevent or reduce abuses of entitlement to such benefits. Maximum size of such fee may be fixed by the Surgeon General and the Social Security Board at an amount estimated to be sufficient to prevent or reduce abuses and not such as to impose a substantial financial restraint against proper and needed receipt of medical benefit. Likewise the Surgeon General and the Social Security Board may limit the application of such fees to home calls, office visits or both.

Participating Hospitals

For a hospital to participate in this insurance program, it must have been approved by the Surgeon General under standards prescribed by him after consultation with the council. A hospital to be approved must provide all necessary and customary hospital services and must be found to afford professional service, personnel and equipment adequate to promote the health and safety of individuals customarily hospitalized in such institution. The Surgeon General may approve or accredit a hospital for limited varieties of cases and may accredit an institution for the care of the "chronic sick." In determining the adequacy of the professional service, personnel and equipment of any such institution, the Surgeon General may take into account the purpose of such limited accrediting, the type and size of community which the institution serves, the availability of other hospital facilities, and such other matters as he may deem relevant.

Application for and Limitation of Hospitalization Benefits

No application by an individual for hospitalization benefits will be valid with respect to any day of hospitalization if the application is filed more than ninety days after such day, or with respect to any day of hospitalization for mental or nervous disease or for tuberculosis after such diagnosis has been made. The maximum number of days in any benefit year for which any individual may be entitled to hospitalization benefit will be thirty. If, however, the funds in the special hospitalization benefit account fund to be created prove adequate, the maximum number of days may be increased to ninety by the Surgeon General and the Social Security Board, acting jointly.

Proposed Method of Administration

The Surgeon General of the Public Health Service will be authorized to take all necessary and practical steps to arrange for the availability of the medical, hospitalization and related benefits. He will be authorized to negotiate and periodically to renegotiate agreements or coöperative working arrangements with appropriate agencies of the United States, or of any state or political subdivision thereof, and with other appropriate public agencies, and with private agencies or institutions, and with private persons or groups of persons, to utilize their services and facilities and to pay fair, reasonable and equitable compensation therefor.

The methods of administration, including the methods of payment to practitioners, the bill provides, shall (1) insure the prompt and efficient care of individuals entitled to benefits; (2) pro-

mote personal relationships between physician and patient; (3) provide professional and financial incentives for the professional advancement of practitioners and encourage high standards in the quality of services furnished as benefits through the adequacy of payments to practitioners, assistance in their use of opportunities for postgraduate study, coördination among the services furnished by general practitioners, specialists, laboratory and other auxiliary services, coördination among the services furnished by practitioners, hospitals, health centers, educational, research and other institutions, and between preventive and curative services, and otherwise; (4) aid in the prevention of disease, disability and premature death, and (5) insure the provision of adequate service with the greatest economy consistent with high standards of quality.

National Advisory Medical and Hospital Council

The bill proposes the creation of a National Advisory Medical and Hospital Council, to consist of the Surgeon General of the United States Public Health Service as chairman and sixteen members appointed by him. The appointed members will be selected from panels of names submitted by the professional and other agencies and organizations concerned with medical services and education and with the operation of hospitals and from among other persons, agencies or organizations informed on the need for or provision of medical, hospital or related services and benefits. Appointed members will hold office for four years, with the terms of office staggered. The appointed members will receive compensation at the rate of $25 a day for time spent on official business of the council, and actual and necessary traveling expenses and per diem in lieu of subsistence.

This council will "advise" the Surgeon General as to (1) professional standards of quality to apply to general and special medical benefits; (2) designation of specialists; (3) methods and arrangements to stimulate and encourage the attainment of high standards through coördination of the services of general practitioners, specialists, laboratories and other auxiliary services, and through the coördination of the services of practitioners with those of educational and research institutions, hospitals and health centers, and through other useful means; (4) standards to apply to participating hospitals and to establishment and maintenance of the list of participating hospitals; (5) adequate and suitable methods and arrangements of paying for medical and hospital services; (6) studies and surveys of the services furnished by practitioners and hospitals and of the quality and adequacy of such services; (7) grants-in-aid for professional education and research projects, and (8) establishment of special advisory, technical, local or regional boards, committees, or commissions.

Relation to Workmen's Compensation Acts

The benefits provided by this bill will not be available with respect to an injury, disease or disability coming within the purview of any state or federal workmen's compensation act.

Dental, Nursing and Other Benefits

The bill devolves on the Surgeon General and the Social Security Board jointly the duty of ascertaining the most effective methods of providing dental, nursing and other needed benefits not contained in the pending bill and of determining the expected costs of such additional benefits. The bill contemplates that the Surgeon General and the Social Security Board will report the results of their findings, with recommendations as to legislation, not later than Jan. 1, 1946.

Grants-in-Aid for Medical Education, Research and Prevention of Disease and Disability

The Surgeon General will be authorized to administer grants-in-aid to nonprofit institutions and agencies engaging in research or in undergraduate or postgraduate professional education. The purpose of these grants will be to encourage and aid the advancement and dissemination of knowledge and skill in providing benefits and in preventing illness, disability and premature death. Such grants-in-aid will be made with respect to each project (1) for which application has been received from a nonprofit institution or agency, stating the nature of the project and giving the reasons for the need of financial assistance in carrying it out, and (2) for which the Surgeon General finds, with the advice of the council, that the project shows promise of making valuable contributions to the education or training of persons useful to or needed in the furnishing of medical, hospital, disability, rehabilitation and related benefits or to human knowledge with respect to the cause, prevention, mitigation or methods of diagnosis and treatment of disease and disability.

This part of the program will be financed by setting aside a certain percentage of amounts expended for benefits from the Federal Social Insurance Trust Fund to be created by the bill. The amount to be set aside will equal 1 per cent of the total amount expended for benefits from the trust fund, exclusive of unemployment insurance benefits, or 2 per cent of the amount expended for benefits under title IX (relating to federal medical, hospitalization and related benefits), after benefits under that title have been payable for not less than twelve months, whichever is the lesser, in the last preceding fiscal year. The bill apparently leaves all the details with respect to these grants-in-aid to regulations to be promulgated by the Surgeon General after consultation with the council.

Self-Employed Individuals

Self-employed individuals may receive the benefits of the old age, survivors, and permanent disability and medical and hospital insurance by paying into the Trust Fund an amount equal to 7 per cent of the market value of their services rendered as self-employed individuals, after Dec. 31, 1943, with respect to services in self employment after that date, but not including that part of any remuneration for employment and the market value of services in self employment in excess of $3,000 for any calendar year.

Employees of States and Local Subdivisions

The bill authorizes the Social Security Board to enter into compacts with individual states or with political subdivisions for the purpose of extending old age, survivors, and permanent disability and medical and hospitalization insurance coverage to employees of such states or political subdivisions. To finance the benefits to be provided under such compacts, the bill requires such employer to pay a social security contribution equal to 3.5 per cent of the wages paid by it after Dec. 31, 1943 and every individual beneficiary of such a compact a

Continued on page 203

Maternal and Child Welfare

Notes on Pediatric Therapeutics

In treating children a sense of proportion is advisable. Most sick children recover in a short time anyway so that bad tasting medicine and uncomfortable procedures very likely will be unnecessary. Of course some unpleasant things have to be done, but the physician should be certain that the benefits make the unpleasantness worth while. He should ask himself, "Will this shorten the illness or point out a change of treatment, or is it just medical curiosity?" "Is it necessary? Can't it be done some other way?" If the doctor will taste the medicine he gives, he may receive a salutary jolt. For example, elixir of terpin hydrate so commonly prescribed by interns tastes terrible, and so does fluid extract of cascara. No child should be required to take a bitter tonic. No physician who values the opinion of his little patients will ever deceive one, or inflict pain without warning.

When treating a child, especially a very sick one, the physician should take care that treatments and investigations are not so frequent that rest is disturbed. Have medicine, nose drops, temperature recordings, etc., come at the same time. The routine four-hour chart is of little use after the diagnosis is established if the patient is doing well, and often disturbs the child for no gain. The "temperature bath" should never be ordered given at some point on the thermometer, but only for restlessness. The cool pack is the best.

Some procedures frequently used in the past may well be dispensed with. No child should ever have his throat painted, and nose drops are not worth fighting over. Few children can gargle, and the value of the gargle is doubtful. The old treatment of castor oil at the onset of an illness can be abandoned without loss. Sweat packs and diaphoretic drugs have no place in pediatric therapy. Incidentally, what is the sense in returning a child from the operating room to a hot bed, piling on blankets, and then having to give a clysis to replace the fluid sweat out? Dietary restrictions based on fever are entirely unnecessary. Nature will take care of that. If a feverish child will eat, he will digest. By the way, milk is not "soft diet." The curd is like rubber. Insistence on the use of the bed-pan may tire a little patient more than picking him up and carrying him to the toilet. Tincture of iodine painted on cuts and abrasions is harsh treatment, and devitalises the skin. The aqueous solution of mercurochrome, while not very potent, is good enough for most such cases and does not hurt.

Probably no therapy in pediatrics is so abused as the cough syrup. You can give cough medicine until you and the child are both blue in the face and unless you remove the cause, you will fail. The treatment is in two separate parts. One, treat the cause. Nine times out of ten in this country it is post-nasal discharge. Two, relieve the cough. This last medicine, the real "cough medicine," must have authority enough to do the work, and will usually contain some opium derivative, occasionally phenobarbital. Paregoric is safe and effective for infants. It is usually given in syrup or well sweetened orange juice. Codeine is good for older children, either as a hypodermic pill folded into a peeled and split grape, or in some syrup such as cocillana. This, the real cough medicine, is given not by the clock but by the cough. Why give it in the daytime if the cough bothers only at night? A dose at bedtime and another in the middle of the night should give a reasonable night's rest. One should not try to suppress every bit of cough. Five to thirty drops of paregoric depending on the size of the baby, or young child, or one-twelfth to one-quarter of a grain of codeine for older children will prove effective. Night cough is helped by elevating the head of the bed. During the day, the patient may as well cough enough to keep the tubes clear, and the cough may be disregarded unless it is excessive.

Efforts should be made to have medication palatable. Generally children prefer liquids to tablets. The latter, if used, should be crushed and given in sweetened orange juice or stewed fruit, such as apple sauce. It is better not to put medicine in milk. Children are apt to dislike alcoholic vehicles such as elixirs and tinctures. Syrup of raspberry and syrup of cherry, both N. F., are popular. Be sure the druggist does not use syrup of wild cherry, which is unpleasant. The following table is copied from a bulletin issued by the Academy of Pediatrics.

TYPE OF DRUG

Saline: Chlorides, iodides, salicylates, bromides, citrates, acetates

Iron Salts: Ferrous Sulphate
Iron and Ammonium Citrates

Bitter drugs: Quinine salts
Bitter alkaloids

Acidulous or Slightly Bitter Drugs: Ephedrine salts, thiamine hydrochloride, codeine salts, Atropine, Syr. Hydriotic acid

Recommended Syrups:
Syrup of glycyrrhiza, USP
Comp. Syr. Sarsasparilla, USP
Syr. of Raspberry, NF.
Syr. of cinnamon, NF.
Syr. of citric acid, USP
Syr. of orange, USP
Syr. cacao, NF.
Syr. Glycyrrhiza, USP.
Syr. of Cherry, NF.

Syrup of sulphadiazine:

Sulphadiazine	5
Syrup of Cherry ad	60

A convenient liquid form for sulphadiazine or any sulpha drug. One teaspoonful contains five grains of the drug. Shake well. To be used within a few days.

YOUR COMMITTEE ON MATERNAL AND CHILD WELFARE.

The Wagner-Murray Dingell Social Security Plan—Continued from page 201

contribution equal to 3.5 per cent of the wages received by him after Dec. 31, 1943, excluding any amount paid or received in excess of $3,000 during any calendar year after Dec. 31, 1943.

BILL AS REVIEWED BY SENATOR WAGNER

On the floor of the Senate, June 3, Senator Wagner described the overall objectives of his bill as follows:

The bill establishes a nationwide system of public employment offices, to help war workers and war veterans to avail themselves of job opportunities, in private industry and on farms, throughout the country. It covers broadly the major economic hazards of average American families—the cost of medical and hospital care, and loss of income in time of unemployment, temporary sickness, permanent disability and old age. It improves the present old age insurance system and extends coverage to 15,000,000 persons now excluded, such as farm workers and domestic servants, employees of nonprofit institutions and the independent farmer, professional and small businessman. All these changes are established under a unified national system of social insurance, with one set of contributions, one set of records and reports and one set of local offices. Reinforcing the job guaranty in the Selective Service Act, the bill gives the returning veteran and his family paid-up benefit rights in every phase of this insurance protection. And, finally, the bill sets up an improved, unified system for grants-in-aid to the states for public assistance, on a variable matching basis, in place of the rigid categories under present law.

PROSPECT OF SENATE CONSIDERATION OF THE BILL

Senator Walter F. George, chairman of the Senate Committee on Finance before which S. 1161 is pending, has been quoted as saying that his committee cannot possibly undertake to give consideration to the bill until late in the present session of the Congress and that if that consideration is given, and if favorable action is taken by the committee, the measure will not reach the floor of the Senate until next year.

Necrologies

Harry W. Smith, M. D., 1870-1943

Harry W. Smith, M. D., for 41 years a practicing physician in Norridgewock, Maine, died August 19, 1943, of a stroke of apoplexy.

Doctor Smith was born in Hampden, Maine, May 1, 1870, the son of Sumner Smith, Jr., and Violetta Patterson Smith. He attended the schools of his native town, was graduated from Hampden Academy and received his degree from Dartmouth Medical College.

He began the practice of medicine in Hampden but established his permanent office and home in Norridgewock in 1902, also serving the neighboring towns of Smithfield, Larone, Rome and Mercer.

He became particularly interested in surgery, and successfully performed major operations under difficult conditions in private homes in the earlier years of practice when there was no other surgeon in his section of the county, and a patient's life depended on his daring and skill. He never lost a surgical case. He was a member of the Somerset County Medical Association, Maine Medical Association, and American Medical Association.

Doctor Smith served his community long and well in his professional capacity, a counselor and friend as well as physician to his patients, a tower of strength in the sickroom, a genial presence in the home. All phases of the welfare of his town engaged his active interest. He was one of a small group of public-spirited men who established the local shoe factory which for thirty years has furnished employment to citizens. He was a Trustee of the Library, a member of the Town Advisory Committee and a Director in the Augusta Trust Company, helping to promote its former branch in Norridgewock; a member of Lebanon Lodge, F. & A. M.; Cedar Chapter, O. E. S.; the Men's Club of the Federated Church, and the Skowhegan Rotary Club.

He read widely on national and world affairs. Visits to Florida and many other places of interest in this Country and Canada, and two trips to Europe reflect his well-rounded life.

Surviving are his widow, Mrs. Grace Perkins Smith, whom he married in 1902; a grandson, Richard Smith Staples; a granddaughter, Ellen Staples; and a great grandson, Richard Smith Staples, Jr., all of Worcester, Massachusetts; three sisters and several nieces and nephews. His only child, Mrs. Erma Smith Staples, the daughter of his former marriage, died in 1941.

Frederick W. Mitchell, M. D., 1873-1943

Frederick W. Mitchell, M. D., 69, a former member of the Maine House and Senate and an executive councillor in 1939 and 1940, died September 5, 1943, after a year and a half of failing health.

Doctor Mitchell was born in Menigomish, N. S., September 14, 1873, the son of James and Jane Grant Mitchell. He received his degree from the University of Maryland Medical School in 1898 and had been an eye, ear, nose and throat specialist in Houlton and nearby Island Falls since 1899.

Doctor Mitchell was a past President of the Maine Eye and Ear Association, and of the Aroostook Memorial Hospital. He was a fellow of the American College of Physicians and Surgeons and a member of the Aroostook County Medical Association, the Maine Medical Association, and the American Medical Association.

He was a member of the Republican State Committee from 1934 to 1937. He was a Vice President of the Houlton Trust Company, a former chairman of the town's School Committee, and had been active in Masonic circles and in civic organizations.

Surviving are his widow, the former Florence Eaton of Portland, and a daughter, Miss Helen Mitchell of Houlton.

COUNTY SOCIETIES

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President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

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President, Francois J. Faucher, M. D., Grand Isle
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County News and Notes

Knox

The Knox County Medical Society met at the Copper Kettle, Rockland, Maine, on August 10th, 1943. The meeting was called to order by A. W. Foss, M. D., of Rockland.

Following the business meeting Paul Millington, M. D., of Camden, spoke on *Treatment of Gastric Ulcers According to the Latest Concept.* The paper was excellent, being both well prepared and concise, and delivered in a very convincing manner.

A. J. Fuller, M. D.,
Secretary.

The Knox County Medical Society met at the Copper Kettle, Rockland, Maine, on September 14th, 1943. The meeting was called to order by A. W. Foss, M. D., of Rockland. The minutes of the previous meeting were read and approved, and Senate Bill 1161 was discussed.

Heinz Magendantz, M. D., of Boston, speaker of the evening, was introduced by Doctor Foss, and spoke on the subject *The Uses of the Electrocardiograph in General Practice.* He told of the many cardiac conditions in which it was a necessity, and those in which it was a valuable aid to diagnosis, and also of diseases not really cardiac but where an electrocardiogram would be an added point in the general picture. His paper was very well prepared and of great interest.

A. J. Fuller, M. D.,
Secretary.

Oxford

The annual meeting of the Oxford County Medical Society was held at Bethel Inn, Bethel, Maine, September 14, 1943. The meeting was called to order by the President, Lester Adams, M. D., Western Maine Sanatorium, Hebron. The following officers were elected for the ensuing year:

President, Pierre B. Aucoin, M. D., Rumford.

Vice President, H. Louella Noyes, M. D., Rumford.

Secretary-Treasurer, J. S. Sturtevant, M. D., Dixfield.

Delegates to Maine Medical Association: H. W. Stanwood, M. D., Rumford, and G. G. Defoe, M. D., Dixfield.

Alternates: Walter G. Dixon, M. D., Norway, and Albert P. Royal, M. D., Rumford.

Committee on Legislation: R. R. Tibbetts, M. D., Bethel.

Councilors: John A. Green, M. D., Rumford; J. A. MacDougall, M. D., Rumford; R. E. Hubbard, M. D., Waterford.

Guests at business meeting: Oscar F. Larson, M. D., Machias, President, Maine Medical Association; Frederick R. Carter, M. D., Portland, Secretary-Treasurer, Maine Medical Association; Wallace E. Webber, M. D., Lewiston; and Robert R. Linton, M. D., Boston, Massachusetts, Surgeon of the Circulatory Clinic of the Massachusetts General Hospital.

Dinner at 7.00 P. M., was followed by a very interesting and instructive lecture, with pictures, on the subject *Major Surgery of the Vascular System*, by Doctor Linton.

J. S. Sturtevant, M. D.,
Secretary.

Piscataquis

The annual meeting of the Piscataquis County Medical Association was held at the Charles Dean Hospital, Greenville, Maine, on September 16, 1943.

Officers re-elected for the ensuing year were:

President, Albert M. Carde, M. D. Milo.

Vice President, Ralph C. Stuart, M. D., Guilford.

Secretary-Treasurer, Harvey C. Bundy, M. D., Milo.

The speaker of the evening was F. J. Pritham, M. D., of Greenville Junction, who presented a very interesting paper on *Caesarean Section*. This was followed by a round table discussion.

Following the meeting a buffet lunch was served by the hospital.

H. C. Bundy, M. D.,
Secretary.

Notice

Medical and Surgical Supplies Needed by Medical and Surgical Relief Committee of America

420 Lexington Avenue, New York, N. Y.

To help the Medical and Surgical Relief Committee continue its vital work of providing emergency medical kits to Coast Guard patrol boats Navy sub-chasers, mine-sweepers and destroyer-escorts, Dr. F. T. Hill, Waterville, state chairman of the Committee, has issued an urgent appeal to surgeons, physicians and medical supply houses for drugs and spare discarded instruments.

Among the items needed to equip the emergency kits are artery clamps, splinter forceps, scalpels, probes, grooved directors, sulfadiazine tablets, sulfadiazine ointment, 5%, sulfathiazole tablets, and sterile shaker envelopes of crystalline sulfanilamide. Other medicines and surgical instruments are, of course, equally welcome.

All salvaged instruments sent in to Committee Headquarters in New York are rigidly inspected, classified and reconditioned if necessary, before they are packed into the casualty units. No open boxes or bottles of medicines are acceptable.

The sub-chaser or patrol-boat kit, specially designed by Committee doctors for the small sub-hunting, doctor-less craft, is a compact case carrying essential medications and an instrument roll. According to Dr. Hill, it is prepared to give immediate treatment to casualties until the ship reaches a base hospital. Dr. Hill pointed out that detailed instructions are included in each medical unit to insure effective use of its contents by non-medical officers.

"Hundreds of appreciative letters in the Committee's files testify to the pressing need for such medical kits," declared Dr. Hill. "They emphasize the urgency of the job the Committee is tackling — a job dedicated to shortening Allied casualty lists. I hope every Maine doctor will contribute a salvaged instrument to the Medical and Surgical Relief Committee — the only war relief agency devoted solely to medical aid."

The Committee, celebrating its 3rd birthday this month, was organized and is conducted by physicians and surgeons, to send medical and surgical supplies to the armed and civilian forces of America and her Allies. To date, over $562,000 of medicines, instruments, vitamins and other equipment have been donated by the Committee to military and maritime units of the United Nations, to needy hospitals, war-zone welfare agencies and civilian defense posts throughout the free world.

Proceedings

MAINE MEDICAL ASSOCIATION

House of Delegates

AUGUSTA, MAINE ❦ **JUNE 20, 1943**

Continued from the September Issue of the Journal, page 187

(Continuation of discussion relative to the Venereal Disease Report Law passed at the last session of the Maine Legislature)

A Member: I think that will take too long; it will all have to be hashed over again, and then it will have to be passed upon by the Association and by the House of Delegates. This law has already gone into effect, and we now find ourselves in the hole before anything is acted upon. I think that it should be discussed now and gone over now, with the House of Delegates already assembled, and I think that it should be decided upon now, because if a committee has to act upon it, they will again have to bring the matter up for action at a future meeting. In that way, much valuable time is lost.

This seems to be a vicious law and it is something that is going to affect us all. I have read it over, and I would say that we also are supposed to publish the names of contacts, and if there is a case of doubtful diagnosis, you are going to find a

libel suit on your hands by going through with that program.

Dr. Foster: I agree that action is important; however, it is a law, signed as an emergency measure, and it doesn't make any difference what the House of Delegates decide here today. They can decide in their own consciences what they are going to do about the law and about their treatment of the patient and the protection of the public health, but the law remains the law, in spite of what we say today.

The proposition is to propose a conference and perhaps bring back a recommendation which will satisfy those concerned, or bring back a proposal to revise the law.

I agree, Doctor, with the fact that it seems to have some serious aspects to it. It would be well to change it, if possible, but I think further discussion here doesn't produce anything, unless Dr. Mitchell has some proposal to make.

Dr. Roscoe L. Mitchell, Director, State of Maine, Department of Health and Welfare: I perhaps might consider myself the physician where the target is aimed right now. But I should like to comment on one or two things that have been talked about here today.

One gentleman said that there is a penalty attached to the law for not doing so-and-so. Well, I suppose any law without a penalty isn't any good. There has been a penalty on the books for forty years or more for not reporting a birth within six days. How many of you have violated that law? There is a penalty on the books and it has been there for forty years, for not reporting a death properly. Yet, because there is a penalty attached to the non-compliance with this communicable disease law—there is a penalty attached to the old law for not reporting "forthwith" as a matter of fact—it constitutes a threat, as it was said here.

Now, I don't think that the law was designed to constitute a threat to the medical profession or anybody else. But, the experience of the people who have been trying to do something about venereal diseases for a great many years brought out the fact that once in a while, two or three or four times a year perhaps, we find some person who is infected with venereal disease—not the innocent party—some loose character who has venereal disease and who insists upon keeping it and spreading it. Those people are pretty wise, and they know that we have no means under the previous statutes by which we can get at them. We could use moral persuasion; we could try bluff, but if they were wise enough, neither one would work. Meanwhile, they would keep on spreading the disease.

As I understand the interpretation of the law—I am not going too finely into the legal entanglements of it as some of our legal friends are able to bring you up to date on that end of it—it supplies a method by which these persons I have spoken about can be compelled to be examined in order to find out whether or not they have venereal disease.

I agree with the gentleman over here that under that particular law we cannot compel treatment. It is not in the law. But we have another law on the statute books by which treatment can be compelled, if they are found to be infected with venereal disease.

I fail to see why any physician should expect to have the penalty attached to that law brought down upon his head. The penalty applies equally to a patient who doesn't comply, or the Bureau of Public Health, if it doesn't comply with certain requirements that are laid down in the law. We are equally liable to that penalty, if we don't carry out our obligations.

As for the diagnosis, and reporting cases within forty-eight hours, the law says, if I remember it correctly and I think I do, that any person known by a physician to have venereal disease, and so forth. Now, that gives you all the time you need to investigate the case, to get the blood reports, the laboratory reports, as many as you need, to make up your own mind to your own satisfaction, and you are the person who judges when you have made up your mind. After you have done that, then the law requires you to report within the forty-eight hours, but not until you have made your diagnosis.

Dr. Kershner: I should like to clarify this in my own mind. Dr. Mitchell said there was another law to compel treatment.

Dr. Mitchell: Yes, that is right.

Dr. Kershner: Is that a recent law, too?

Dr. Mitchell: Yes.

Dr. Kershner: When was that passed?

Dr. Mitchell: It was passed at the last session; it is in Chapter 330.

Dr. Kershner: But it is not a part of this law?

Dr. Mitchell: No.

Dr. Carswell: May I ask Dr. Mitchell a question? Dr. Mitchell, does that permit a physician to bring up again or recall a case or any number of cases that he may know of who are infected and who, he knows, have not been under treatment previous to enactment of this law?

Dr. Mitchell: I am afraid that some lawyer would have to answer that question. I cannot give you the answer.

Chairman Larson: Please state your question again to Mr. Locke and perhaps he can answer it for you.

Dr. Carswell: I asked Dr. Mitchell if this law permitted the reporting of a known case of venereal disease that had been discovered—I should have said reporting again a known case of venereal disease that had been picked up and discovered previous to the enactment of the present law and that has not as yet gone under treatment?

Herbert E. Locke, Esq., Association Attorney: No, I should think it would not. It says "within forty-eight hours of the time it came to his knowledge." You mean if it came to his knowledge months before, would he have to report it again?

Dr. Carswell: We have no way of bringing these cases known to have venereal disease under treatment at the present time, except that they were, perhaps, to report for examination again.

Mr. Locke: I shouldn't think the way the law reads, and this is just a first impression, that you would be compelled to report such a case that came to your knowledge before the law took effect, because the law contemplates that you will report cases within forty-eight hours after they come to your knowledge. That would be my impression, but the Attorney-General might consider otherwise, when he reads the thing all through. "Within forty-eight hours after the time the fact comes to his knowledge." Well, I should think that was exhausted within that time. As I have said, that is my first impression. On the other hand, of course, I suppose the Department and those interested in the accomplishment of the purpose of the law would like to have you folks comply with the spirit and the purpose of it, and not seek to escape by the means of just the letter of the law alone, and report any case that failed to be reported previously, when this law was not in effect.

Dr. Carswell: This case had been reported, Mr. Locke, previously—this one in particular that I am speakng about—but the case has never yet been under treatment. I am afraid that this is a case which is capable of spreading infection. The question in my mind is this. Is there anything in the present law which will permit that case to be reported again?

Mr. Locke: I am distinguishing between "permit" and "require." As far as the law reads, you are permitted to report it, I suppose, any time. So far as being compelled to do so, I don't suppose you are compelled to do so, unless the exact circumstances of the law exist. So that my answer is that they won't compel you to do so after that time expired. But I may be wrong on that. What do you say about that, Dr. Mitchell?

Dr. Mitchell: I would think that the intent of the law is to report any person who has lapsed from treatment, who isn't taking treatment, so that he might be brought under treatment. That would be my opinion.

Mr. Locke: Then I think to accomplish that result, you would have to have in the law another section which would say: "This is applicable to cases which were in existence and known to the doctor when the law took effect."

Dr. Harold W. Stanwood, Rumford: As a physician in charge of a venereal clinic in Oxford County, I feel that this is an undemocratic law. I think it is discrimination against the poor, and for the rich. People come to the clinic in Oxford County and register a protest as regards their names going in to the State Department as having infectious venereal disease.

I feel that this House of Delegates should go on record to bring some pressure to bear in legislative circles to repeal this law. I don't think it is fair in any way. There is no reason why a patient who goes to a private physician should be exempt from reporting any more than there is required from a patient who goes to a clinic. I think it is undemocratic.

Dr. Holt: Isn't the only fly in the ointment the reporting by name? In other words, you do have to report your private patients and you report everything but the name. If it is just the name that is the sticker, as I understand it, on condition that the name, etc., are reported; otherwise, the Health Department would not have the funds to carry on. Isn't it the fact that it is just reporting by name that is bothering you all?

Dr. Johnson: And the address, too, on the clinic patients.

Dr. Mitchell: May I say one word more, with reference to this matter of reporting by name? I can quite agree with some of the gentlemen with reference to the reporting by name of certain patients and not others as being, perhaps, somewhat discriminatory, if you wish to put it that way.

Now, the original bill required all patients to be reported by name. As far as I am personally concerned, I have no objection to that. But there was a move, I believe, in the Legislature to forbid reporting by name in any case, and, as one doctor has just said, we get Federal money for the treatment of venereal dsease and for the payment of treatment by clinicians; when the Federal recorder comes around, he demands that there be a name for whom we spend money for treatment. In that way, the requirement that persons for whom the State Bureau of Health incurs obligations for treatment should be reported by name came into being.

I am not here to say it is fair; I am telling you how it happens to be in there, in that way.

Now, as far as I am concerned, I see no objection to reporting them all by name, rich and poor and everybody else. I shall be very happy to have an expression of opinion of all the gentlemen here with reference to that.

Dr. Johnson: We, in Portland, are not anxious to see an increase of Venereal diseases, but we do feel that the individual indigent should have the same respect as the private cases.

Dr. Frank A. Smith, Westbrook: We haven't had a chance to express our opinions and our advice during the last year. I am particularly interested because I have for the past ten years had a chance to watch the working of the old law. At the reformatory, where I get young men from all over the state of Maine, there is an unbelievable decrease in gonorrhea and syphilis. I practically never see a case of gonorrhea now, either active or chronic, because they have been treated so well outside, and have gone to clinics. Instead of a dozen syphilitics, I may have one or two only, under treatment.

I think that anything that adds publicity to the individual is going to set treatment of the venereal diseases, both private and public, back for thirty or forty or fifty years.

I am utterly opposed to the naming of these people or their addresses.

To be continued in the November Issue

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A Discussion and Case Report on Myasthenia Gravis

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Myasthenia gravis appears more and more often in recent case reports. This is probably not because of its more frequent occurrence, but because of its more frequent recognition. Years ago patients, who were misdiagnosed as "neurotics," circulated from physician to physician. Now, these patients are correctly diagnosed with our new diagnostic means, as myasthenia gravis, undulant fever, and hypoglycemia.[1] Though we are able to recognize more and more occult ailments previously appearing as neurosis to us, there still is a great number that we have to classify as neurosis, or as a newer term, "constitutional inadequacy." This diagnosis is especially unsatisfactory to the patient. No doubt, due to our progress, we shall be able to diagnose this group more specifically and cut down on the number of those broadly diagnosed as neurotics. One of these inadequacies is myasthenia gravis and it can be successfully treated today.

The pathology reveals lymphorrhages in small foci in muscles and other parts of the body in about sixty per cent of the cases. Besides lymphocytes, mucolytic, fatty degeneration, and vacuolization, as well as an increase of nuclei in the sarcolemna are described. Inconstant findings are changes of the central nervous system and a persistent thymus.

The symptomatology is characterized by the marked exhaustibility of the muscular system. This may develop after continual exercise into a complete paralysis, and disappear after a short rest period. In the progress of the disease, a complete paralysis may develop without previous activity. The sensation of weakness in one muscle, or a group of muscles, pains, and parasthesias may develop. Bilateral or unilateral ptosis due to weakness of the levator palpebrae superioris is often the first manifestation. Then weakness of the extrinsic muscles of the eyeball cause diplopia. Finally complete external ophtalmoplegia occurs. The involvement of the facial muscles produces an apathic expression, and together with the ptosis, a sleepy expression occurs. This produces a peculiar laugh or smile described as a "nasal snarl." Levy[2] describes it as "a parkinsonian mask with absence of tremor and atrophy." The mouth may remain open due to the involvement of

the muscles of mastication. Furthermore, the involvement of all muscles of deglutition may cause difficulty in swallowing. Laryngeal muscle involvement may cause hoarseness, a nasal talk, and later aphonia as the patient talks for any length of time. The involvement of the muscles of the neck make it impossible to support the head. Levy[2] emphasizes the possibility of the involvement of the myocardium. Unlike muscular dystrophy, myasthenia gravis has no marked atrophy of muscles. There are reports of the loss of special senses. Smooth muscles may also be involved.

Diagnosis is made by characteristic muscle involvement. There is an absence of atrophy. General weakness follows exertion. Rapid recuperation occurs after rest. The presence of lymphorrhages can be found in biopsy specimens. Alteration of the creatine and creatinine ratio is claimed by some authors as typical. Five minutes after a hypodermic injection of prostigmin methylsulfate, a noticeable improvement occurs in the involved muscles.

Ethiology remains obscure. There is a basis for defective production of acethylcholine at the myoneural junction. This is either due to a disturbance of normal balance between acethylcholine production and its destruction by cholin esterase, or there may be a curare-like substance at the myoneural junction. The similarity of myasthenia gravis and curare poisoning caused early observers to use first physostigmine, and later prostigmin, as treatment. Disturbance between creatine and creatinine relationship, likewise found in muscular atrophies, is supposed to be an ethiological factor. Levy[2] reports a distinct relationship between exacerbation of muscular weakness and creatine output and creatine level in one case. Also enlarged and persistent thymus was considered responsible for myasthenia gravis.

As treatment, the patient must have adequate physical and mental rest. Food must be easy to chew and swallow, in case the patient has a disturbance of mastication. The food must be eaten slowly in order to give those muscles enough rest for recuperation. It also may be necessary to feed the patient through a nasal tube. The following drugs were tried and used: arsenic, phosphorus, elixir of iron, potassium chloride, ephedrine, amino acetic acid, guanidine hydrochloride, quinine, strychnine, glycine, calcium, adrenaline, pituitary extracts, cortical extracts, benzidrine sulfate, glycocoll, extracts of the adrenals, ovarian and testicle extracts. X-ray therapy to the supposedly persistent thymus and its surgical removal were reported as successful. Finally, one of the most dramatic drugs, as far as its supposed specificity[3] and success is concerned, is prostigmin given orally and subcutaneously. Atropine should be given simultaneously to obviate the intestinal effects. The fact that so many drugs were used shows that no definite treatment has been approved, but prostigmin seems to be the drug of choice now.

The patient reported here had many of the drugs mentioned above, in succession, as a trial. Then it was left to his judgment to decide the drug that gave him the most benefit. He decided upon prostigmin.

Case Report

A white, male, 68 years old, gave the following history: His father died of "heart trouble," his mother died of "old age," and his sister of "spinal trouble." His past history reveals "inflammation of the bowels" at the age of six. A "nervous breakdown" at forty-two, lasted for three years. At fifty-eight, he fell from a tree injuring his spine and this necessitated a long bed confinement. Afterwards, he had to be strapped up in order to remain in an upright position. He is a moderate drinker and smoker. The present illness dates back one and a half years, when he gradually became "lame." Though tiring easily he kept on working. He lost some vision, and diplopia developed. He was unable to voluntarily lift his right upper lid. This gave him a sleepy expression. He kept his eye-lid up with adhesive tape. He was unable to chew, thus he complained of having a "bad appetite." From a kneeling position he had to "climb up on himself" in order to stand upright. At that time, he was so weak that he had to be strapped up in his lumbar-spine region in order to walk in upright position. A review of systems was essentially negative, except for his occasional constipation and a nonproductive cough.

Physical examination: An over-middle-aged, undernourished-appearing, male had a temperature of 98, pulse was 70, respiration 20, blood pressure bilaterally was 100 systolic and 60 diastolic. He was not appearing acutely ill.

Examination of the head revealed his ears, especially the left, lacking bone and air conduction. Otoscopic examination was negative. Nose and throat were negative. Tongue protruded in midline, no coating seen. Teeth were removed. Eyes revealed an arcus senilis. The left upper eye-lid was ptotic. The pupils reacted normally to light and accommodation. Extraocular movements were slow.

There was a gland measuring 2 cm. in diameter palpable in jugulum.

Chest: The lungs expand equally bilaterally. The percussion note was resonant. Auscultation revealed vesiculary breath sounds throughout. The heart was within normal limits on percussion. No murmur was heard.

Abdomen: The liver was enlarged one hand breadth below the costal margin. No other organs or masses were palpated. There was neither rigidity nor tenderness.

Genitalia were negative. The rectal examination was negative. Reflexes were physiological. The sensations for touch and temperature were normal.

Laboratory findings: (Done in the State Laboratory, Augusta, Maine.)

N. P. N. was 28.5 mg%. Urea nitrogen was 13 mg%. Blood sugar was "too weak to read." Agglutination for undulant fever, typhoid, paratyphoid, protein x_{19} were negative. Hemoglobin was 70%. Hinton was negative. One year later creatine was 2 mg%, blood sugar 111 mg%.

Course:

1 cc. of 1:2000 prostigmin methylsulfate subcutaneously was given. The patient returned after an hour, without being told beforehand about the possible effects, to report that he was able to chew for the first time in years. After this test dose the patient was given the following drugs as trial: Glycocoll, amino acetic acid, benzidrine sulfate, ephedrine hydrochloride, cortical extract, guanidine hydrochloride, and prostigmin bromide. All of these drugs seemed to improve the patient's condition, but prostigmin bromide helped him more than any other drug by his own statement. The patient gained weight, felt better, could eat and chew better, and the strapping could be removed after a few days of treatment. He could do his work better. He experienced less fatigue. He had more ambition and felt stronger. He could walk upright. The ptosis disappeared completely and he was not troubled anymore with diplopia. In addition to the drugs mentioned above, the patient was also given vitamin preparations, liver extracts and a high protein diet because of his hypoglycaemia. As the patient stated that prostigmin bromide helped him most, he was given it for the following months. The medication was discontinued whenever he felt strong enough and started again at the beginning of any weakness.

However, eight months later he had an attack of dyspnoea, or as he called it from his previous experiences "asthma." On physical examination, hyperresonance on percussion and musical rales on auscultation were found throughout the chest. His pulse was 86, his temperature 98, blood pressure 80 systolic and 00 diastolic. A trial of ephedrine sulfate did not have any effect. Digitalis was given without effect. He was again unable to chew, was orthopnoic, felt generally "weak." One tablet of 15 mg. prostigmin bromide was given three times daily. This caused the "asthma" to disappear. He was able to chew again after one week. This dyspnoea apparently was due to involvement of the respiratory muscles.

Comment

This case was reported because of the dramatic effects of prostigmin in a case of probable myasthenia gravis. The word "probable" is made, because of the fact that the diagnosis is based on the therapeutic effects of a supposedly specific[3] drug. Prostigmin relieved unilateral ptosis, inability to chew, diplopia and dyspnoea. It was not necessary to take prostigmin continuously, but it had to be given at remissions.

Continued on page 225

Pfeiffer Bacillus Meningitis

A Review of the Cases Treated by Chemotherapy. Report of a Case Treated with Sulfadiazene and Immune Serum with Recovery.

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It was extremely rare for a patient with Pfeiffer Bacillus (B. Influenzae) meningitis to recover before the use of either immune serum and chemotherapy. Immune serum and sulfanilamide were used alone and in combination with disappointing results. Sulfapyradine gave a higher percentage of cures but the mortality rate was still very high, as inspection of Table II will show.

The excellent results reported for the use of Sulfadiazene in the treatment of meningococcus meningitis, prompted us to try this new sulfonamide in the treatment of a patient with Pfeiffer Bacillus meningitis.

Case Report

Male patient, aged 8 years.

Present Illness:

Began on the morning of August 13, 1941, with a complaint of sore throat, headache and pain in the back of his neck. Fever was noted the same evening and was accompanied by nausea and vomiting. The latter was recurrent over a period of three or four hours. It soon became rather difficult to arouse him and he appeared to lose consciousness completely for a period of one-half hour about 11 P. M. Thereafter it was noted that he had spells of restlessness lasting a few minutes, following which he would quiet down and sleep for short intervals. Incontinence of urine was noted once. He continued to be difficult to arouse and to complain of headache. His mother observed that he had muscular rigidity, that there was a tendency for him to keep his mouth clamped tightly shut and that he continued to be feverish. Meningitis was suspected and a lumbar tap performed during the second evening which yielded cloudy spinal fluid under increased pressure.

Past History:

Revealed whooping cough and pneumonia at the age of six years.

System History:

Cardio-Respiratory: A few colds in the past. No cough, no ankle edema, no dyspnea. His mother is of the opinion that the boy may be asthmatic. No complaint of chest pain elicited.

Gastro-Intestinal: Appetite fair. Bowels regular with normal stools. No jaundice and no diarrhea.

Genito-Urinary: No burning. No nocturia, no hematuria. Urine not cloudy.

Family History:

Father living but suffers from asthma. Mother and one sister alive and well. No family history of tuberculosis, renal, cardiac or CNS disease, or diabetes.

Physical Examination at Entry:

Temperature 103°. Pulse 140. Respirations 50.

The child was comatose and had marked opisthotonos, positive Kernig sign and Brudzinski sign, absent knee jerks and ankle jerks and absent abdominal reflex. External painful stimuli resulted in hyperactive responses on the part of the patient. Babinski and Gordon signs were negative.

There was a thick whitish nasal discharge. Inspection revealed normal ear drums and pupils which were equal, regular and reacted to light and accommodation. There was no evidence of nystagmus, strabismus or choking of the discs. The tongue was coated and there was a tendency to keep the mouth tightly closed. Tonsils were not enlarged though the pharynx was somewhat injected. Cervical adenopathy was not present but there was definite stiffness of the neck and retraction of the head. The chest was symmetrical. Lungs resonant throughout and the heart negative except for an occasional extra systole. Abdomen and genitals were negative.

A lumbar puncture showed a spinal fluid under greatly increased pressure and which

was cloudy. Smear of the fluid showed many polymorphonuclears and many pleomorphic gram negative bacilli, which on culture proved to be B. Influenzae.

Laboratory Data:

Haemoglobin 86% Sahli. Rbc 4,830,000. Wbc 29,000. C. I. 0.9. Differential count showed 87% polymorphonuclears, 8% lymphocytes, 5% mononuclears, and of the polys 6 were stabs and 81 segs.

Urine showed specific gravity of 1.028, no albumen, no sugar, large trace acetone, negative sediment.

Throat culture showed gram positive cocci in clumps and short chain formations which produced hemolysis on the blood plate and were thought to be hemolytic streptococci.

Treatment:

A twenty-grain dose of Sulfanilamide was begun on 9 P. M. and on the second day of illness and was followed by ten grains at 10 P. M. and 11 P. M. No further Sulfanilamide was given; but at 12:45 noon on the third day of illness, an initial dose of three grams of Sulfadiazene was administered through a Levine tube. The subsequent amount of Sulfadiazene with the blood and spinal fluid levels, the blood count, the temperature and pulse, etc., are best visualized by examination of the accompanying clinical chart.

This patient was found to be sensitive to horse serum and desensitization was necessary before the anti-influenzal bacillus serum (Fothergill's) obtained from the Massachusetts Board of Health could be administered. Despite this desensitization the patient got an almost immediate anaphylactic reaction with the first dose of intravenous serum. This was relieved by adrenalin but it was thought best to administer all of the remaining anti-influenzal meningitis serum intramuscularly.

The patient remained very restless and refused to take fluids by mouth for the first four days. Then on August 18th, some improvement was noted in that the patient became quieter, was able to swallow fluid, and began to respond to questioning. He continued to have a thick whitish nasal discharge for the first four days. On the sixth day, flacid paralysis of the left arm developed but cleared completely after two days, without any residual effects. On the seventh day he suddenly became spastic, developed lateral nystagmus of both eyes, which episode lasted ten minutes. On the eighth day there was a similar attack with twitching of the eyelids, facial muscles, fingers of the left hand, and regular clonic contractions of the left arm and pectoral muscles. Four grains of Pentothal sodium were required to terminate this attack. Subsequently his condition began to improve daily with a fall of temperature to 100° by the ninth day and to normal by the thirteenth day of his illness. Sulfadiazene was discontinued on the fourteenth day but the temperature rose to 101° three days later. The drug was resumed and continued for another eighteen days. The temperature quickly dropped back to normal and continued so after the twenty-second day of his illness.

When seen four months later he continued to be entirely well and the neurological examination was entirely normal.

A perusal of the literature has revealed that there was much pessimism about the therapeutic value of immune serum, Sulfanilamide and Sulfadiazene in the treatment of Pfeiffer Bacillus meningitis. A few attempts had been made to review the cases reported in the literature but the data included in these summary tables was entirely too meagre to allow any critical evaluation as to adequacy of the treatment. Consequently, an attempt has been made here to include more essential details such as the amount of the drug given, duration of treatment, blood and spinal fluid culture reports, concentration of the drug in the blood and spinal fluid, and post-mortem findings, when such of this information was available. In Table I there is a summary of all the Pfeiffer Bacillus meningitis cases the author was able to find treated with Sulfanilamide forming drugs. Table II includes a similar tabulation of those patients treated with Sulfapyradine. Table III includes the cases treated with Sulfathiazole and Table IV lists those treated with mixed therapy.

Table I

Summary of Cases Treated with Sulfanilamide

Reference	No. Cases Reported	Age of Patient	Drug and Amount	No. Days Drug Administered	Drug Level in Blood	Drug Level in Spinal Fluid	Blood Culture	Spinal Fluid Culture	Specific Serum	Result	Comment
Folsom & Gerchow W. Va. Med. J. 34:254, 1938	1	10 yrs.	Sulfanilamide I. Sp. Prontosil 10 c.c. daily then Sulfanilamide 30 grs. p. o.	? ? ?				Positive		Recovered	
Gordon Maine Med. J. 29:65, 1938	1	7 yrs.	Prontylin 5 to 10 grs. q4° Prontosil 30 c.c.	? 1 day				Positive		Recovered in 18 days	
Bachuber Wisconsin J. Med. 37:399, 1938	1	3 yrs.	Sulfanilamide p. o. 310 grs. Prontosil 190 c.c. Sulfanilamide 1 sp. and s. c. 1% sol. 4031 c.c.	16 days 6 days 10 days				Positive		Deceased	
Teggart Br. Med. J. 1:1365, 1938	1	60 yrs.	Soluseptasine 9 gms. daily	7 days				Culture Negative Smear showed gram neg. bacilli		Recovered after 23 days	
McIntosh, et al. J. Pediat. 11:167, 1937	2	6 yrs.	Sulfanilamide 1.8 gms. daily	10 days				Positive	Anti Influenzal serum given i.v. and i.the. b.i.d.	Died	
		6 yrs.	Sulfanilamide 3.6 gms. daily	? 14 days			Positive	Positive	Anti Influenzal serum given i.v. and i.the.	Died	
McQuarrie J. Pediat. 11:188, 1937	1	22 mos.	Prontylin 800 grs. (total)	24 days					Anti Influenzal serum given intrathecally	Died	Post-mortem Findings of purulent meningitis
Basman & Perley J. Pediat. 11:212, 1937	1	1 yr.	Sulfanilamide 1 gm. daily (parenterally)	1 day	11.8 mgs.	9 mgs.	Positive			Died after 24°	Child evidently moribund before treatment begun
Jones Br. Med. J. Oct. 23, 1937, p. 797	1	2 y. 10 m.	Sulfanilamide ? amount	?				Positive	Anti Influenzal serum given intrathecally	Recovered	
Taylor Arch. Pediat. 55:131, 1938	1	4 yrs.	Sulfanilamide 520 grs. (total) Prontosil 520 c.c. Prontylin 5-10 c.c. (8% sol. in 0.9% saline)	14 days 14 days ?				Positive	Anti Meningococcal serum given intraspinally	Died	
Young & Moore Arch. Pediat. 55:282, 1938	1	5 yrs.	Sulfanilamide 45 grs. daily Omitted for 7 days then 45 grs. daily	8 days 3 days				Positive Negative on 7th day after drug started	Anti Meningococcal serum (105 c.c. in 7 days)	Recovered in 45 days	
Montestrue et al. Bul.de la Soc.de Path.Exotique 31:10, 1938, p. 892	1	2½ yrs.	Daginan 8 gms. (total)	9 days			Positive	Positive		Recovered in 11 days	
Mass. Gen. Hospital Case No. 24382 (Mallory, editor) N. E. J. Med. 219:443, 1938	1	8 mos.	Sulfanilamide 15 grs. daily Prontosil 18 c.c. then Prontylin 7.5-15 grs. throughout much of hospital stay	3 days 4 days ?			Positive	Positive	Anti Influenzal serum 375 c.c. (total)	Died 29 days after onset	Post-mortem Findings: 1. Influenzae B. meningitis 2. Thrombophlebitis (rt. lateral sinus) 3. Acute purulent atitis media

		3 mos.	Prontosil 2.5% 790 c.c. given s.c. & i.the. & in. cist. Sulfanilamide 0.8% 125 c.c.	6 days 1 day					Positive	Died 2 weeks after treatment started
Waring J. So. Carolina Med. A. 35:884, 1939	6	3 yrs.	Sulfanilamide 1 gr. per lb. per day	?					None	Died
		8 mos.	(ditto)	?	2 mgs.				None	Died — Post-mortem Finding of liver degeneration
		1 yr.	(ditto)	?					None	Died on 2nd day
		7 mos.	(ditto)	4 days					None	Died
		1 yr.	(ditto)	?					None	Died on 10th day
		5 mos.	(ditto)	?						Died on 10th day
Brown et al. Arch. Otol. 29:860, 1939	1	6 yrs.	Prontosil 20 c.c. Sulfanilamide 2 gms. Sulfanilamide 1.3 gms. daily	4 days 3 days 11 days			Negative	Positive Negative after 10 days		Recovered in 18 days
MacKenzie, Page and Ward The Lancet April 27, 1940, p. 785	2	10 mos.	Prontosil album. 24 gms. + Prontosil rubrum 15 c.c. intrathecally	12 days				Positive on 2 occasions		Death after 12 days — Post-mortem Findings: 1. Meningitis 2. Petechial hemorrhages
		10 mos.	Sulfanilamide 78 gms. (total)	17 days				Positive		Death after 17 days of treatment — Post-mortem Findings: 1. Meningitis, purulent 2. Hydrocephalus, internal
Dowds The Lancet July 27, 1940, p. 101	1	3½ mos.	Prontosil rubrum 1⅓ Tablets	4 days				Positive		Died after 4 days of treatment — No post-mortem. Meningitis was preceded by abscess on buttock
Baumgartner & Nuzum Wisconsin Med. J. July, 1941:579	1	39 yrs.	Sulfanilamide p.o. 74.35 gms. (total)	24 days	3 to 25 mgs.	3 to 20 mgs.		Positive		Recovered after 32 days
Eldahl Ugesk. f. Laeger 101:88, Jan. 19, 1939	3	4 yrs.	Sulfanilamide intraspinally 5 to 20 cm. daily, 100 cm. i.v.	5 days				Positive at hospital entry Negative 5th day after		Recovered
		18 mos.	Sulfanilamide (parenterally)	9 days				Positive at hospital entry Negative after 8 days		Recovered
		3 yrs.	Sulfanilamide p.o. i.sp. i.m.	12 days				Positive		Died in 14 days
Lindsay, Rice & Sellinger J. Pediat. 17:Aug., 1940	2	?	Sulfanilamide	?					Specific serum c guinea pig complement	One recovery One death — No details given
	5	?	Sulfanilamide	?					Specific serum c human complement	Two recoveries Three deaths — No details given
Mutch The Lancet Dec. 20, 1941, p. 751	3	30 yrs.	Sulphonamide E.O.S. 80 gms.	7 days				Cultures all sterile		Recovered — Temperature normal in 24°
		16 yrs.	Sulphonamide E.O.S. 80 gms.	7 days				Cultures all sterile		Recovered
		6 yrs.	Sulphonamide E.O.S. 12.5 gms.	2 days				Positive		Died 62 hours after hospital entry

Table II

Summary of Cases Treated with Sulfapyradine

Reference	No. Cases Reported	Age of Patient	Drug and Amount	No. Days Drug Administered	Drug Level in Blood	Drug Level in Spinal Fluid	Blood Culture	Spinal Fluid Culture	Specific Serum	Result	Comment
Roche & Caughey The Lancet 237 :635, 1939	2	17 mos.	M&B 693 20.26 gms.	12 days				Positive		Recovered in 42 days	
		12 yrs.	M&B 693 47 gms. Proseptasene 6 gms. M&B 693 106 gms.	6 days 1 day ?(5 courses)				Positive		Recovered in 46 days	
Hamilton & Neff J. A. M. A. 113 :1123, 1939	1	2 yrs.	M&B 693 14.06 gms.	26 days			Positive H. Influenzae	Positive Negative on 5th day		Recovered	
Waring J. So. Carolina Med. A. 35 :884, 1939	5	6 mos.	Sulfapyradine 1 gr. per lb. daily dose	?	0.8 mgs. on 17th day of treatment					Died	Treatment started 10th day of illness
		3 yrs.	(ditto)	?	0.9 mgs. 5.5 mgs. 14.8 mgs. 3rd day of treatment					Died	
		5 mos.	(ditto)	?	7.5 mgs. (3rd day) 4.09 mgs. (7th day)					Died	
		6 yrs.	Sulfapyradine 45 grs. daily	24 days		33 mgs. on 6th day		Positive		Recovered in 41 days	
		22 mos.	Sulfapyradine 846 grs. (total)	36 days	2.4 mgs. on 11th day			Positive Negative on 35th day		Recovered in 39 days	
Aleman (Incl. cases at Charity Hosp.) New Orleans Med.& Surg.J. July, 1940, p. 25	10	19 mos.	Sulfapyradine	?						Died	No details given
		6 mos.	(ditto)	?						Died	No details given
		3 mos.	(ditto)	?						Died	No details given
		11 mos.	(ditto)	?						Died	No details given
		7 mos.	(ditto)	?						Died	No details given
		2 yrs.	(ditto)	?						Died	No details given
		2 mos.	(ditto)	?						Died	No details given
		5 mos.	(ditto)	?						Died	No details given
		9 mos.	(ditto)	?						Died	No details given
		5 yrs.	(ditto)	?						Died	No details given
MacKenzie, Page and Ward The Lancet April 27, 1940, p. 785	1	7½ mos.	Sulfapyradine 37 gms.	11 days				Positive on 3 exams.		Died in 11 days	Post-mortem Findings: 1. Purulent meningitis 2. Dilated lateral ventricles
McLean, Wood & Henderson Am. Int. Med. 14 :331, 1940	1	30 mos.	Sulfapyradine 23.25 gms.	18 days			Negative	Positive Negative 4th day of treatment		Recovered after 20 days	
Sirlin & London J. Pediat. 17 :228, 1940	1	27 mos.	Sulfapyradine p.o. 30 gms. Sod. Sulfapyradine 2.1 gms. Neo Prontosil 2.5% i.sp. 30 cc.	14 days ? 1st 4 days		Varied from trace to 7.5 mgs. %		Positive		Recovered after 17 days	No residual neurological signs one month after discharge
Arnett, Shoup & Henry Am. J. Med. Sc. 200 :#5, 1940, p. 674	1	13 yrs.	Sulfapyradine 47 gms.	10 days			Positive	Positive 1st two times, then negative		Recovered Discharged after 37 hospital days	Complicated by bilateral ureteral obstruction with uremia
Roberts Br. Med. J.	1	6 yrs.	Sulfapyradine 31 gms. Sulfapyridine 194 gms.	20 days				Positive		Recovered	

The Laneet Mar. 30, 1940, p. 597							days treatment			ment
Dowds The Lancet July 27, 1940, p. 101	1	3 yrs.	M&B 693 0.25 gms. initial dose then 0.12 gms. 3 times daily	Not given			Positive		Died	Post-mortem showed purulent meningitis. Meningitis preceded by subcutaneous abscess on elbow
Noone & Kennedy J. A. M. A. Dec., 1940, p. 2060	1	5 yrs.	Sodium Sulfapyradine 5% sol. 54 gms. (total) Sulfathiazole 24 grs.	18 days 6 days		Negative	Positive	Anti Influenzal serum 160 c.c.	Recovered	
Mutch, N. The Lancet Dec., 1941, p. 751	2	17 mos.	Sulfapyradine 34.5 gms. then after an interval of 1 week pt. given Sulfapyradine 32 gms.	14 days 15 days			Positive		Died on 36th day after entry	Post-mortem Findings: Brain showed thick yellow pus over base and surrounding optic nerves
		7 mos.	Sulfapyradine 18 gms.	8 days			Positive	Serum given i.v. and i.the.	Died	Post-mortem Findings: Severe purulent meningitis
Jacoby, N. M.	1	1 yr.	Sulfapyradine 17 gms.	7 days			Positive		Completely cured 9 days after admission	
Lindsay et al. J. Pediat. 17:1940	3		Sulfapyradine					Serum and human complement	Two recoveries One death	No details given
Neal et al. J. A. M. A. 115:2055, 1940	17	2½ yrs.	Sulfapyradine	?		Negative			Recovered	Injury and infection of orbit; relapse
		2 yrs.	Sulfapyradine	?		Negative	Positive		Recovered	Prompt recovery
		9½ yrs.	Sulfapyradine Sod. Sulfapyradine	?		Negative		Serum intraspinally	Died	Began as brain abscess; operation. Necropsy, large brain abscess
		3 yrs.	Sulfapyradine Sod. Sulfapyradine	?		Negative			Recovered	
		3 yrs.	Sulfapyradine Sod. Sulfapyradine			Positive		Serum intraspinally	Died	Bloek
		1¼ yrs.	Sulfapyradine Sod. Sulfapyradine	?		Positive		Fothergill's serum plus complement	Died	
		1⅙ yrs.	Sulfapyradine Sod. Sulfapyradine	?		Negative		Serum intraspinally	Died	
		2 yrs.	Sulfapyradine Sod. Sulfapyradine	?		Positive			Died	Diagnosis made two weeks after onset
		4 yrs.	Sulfapyradine Sod. Sulfapyradine	?		Negative			Recovered	Responded in three days
		3 yrs.	Sulfapyradine p.o. (inadequate dose) Sod. Sulfapyradine	?					Died	Double otitis media. Clinical mastoiditis
		5½ yrs.	Sulfapyradine p.o. Sod. Sulfapyradine	?		Negative		Serum	Recovered	Mastoidectomy—otitis. Relapse.
		1 yr.	Sulfapyradine p.o. Sod. Sulfapyradine	?				Serum i. sp.	Died	Bloek
		4 yrs.	Sulfapyradine Sod. Sulfapyradine	?		Negative		None	Recovered	No treatment intraspinally
		9 mos.	Sulfapyradine p.o. Sod. Sulfapyradine	?		Negative		Small amount of serum	Died	
		22 yrs.	Sulfapyradine Sod. Sulfapyradine	?				Serum intraspinally	Recovered	
		35 yrs.	Sulfapyradine p.o. Sod. Sulfapyradine	?		Negative		Serum intraspinally	Recovered	Followed submucous resection and ethmoidectomy
		8 mos.	Sulfapyradine p.o. Sod. Sulfapyradine			Negative		Serum intraspinally	Died	
Jacobson & Neter Am. J. Dis. of Children 60:363, 1940	1	1 yr.	Sulfapyradine 196 gms.	26 days	1.7 to 13.7 mgs. %	Positive Negative after 14 days		Anti Influenzal serum 210 c.c.	Recovered after 25 days of treatment	Spinal puncture on the 31st day was normal. Child has remained well.
Neter, E. Arch. Path. 28:603, 1939	1	18 mos.	Sulfapyradine 205 gms.	27 days				Anti Influenzal serum 213 c.c.	Recovered	Sulfanilamide was given intrathecally; amount not given.

Table III

Summary of Cases Treated with Sulfathiazole

Reference	No. Cases Reported	Age of Patient	Drug and Amount	No. Days Drug Administered	Drug Level in Blood	Drug Level in Spinal Fluid	Blood Culture	Spinal Fluid Culture	Specific Serum	Result	Comment
Patterson, R. A. and Crumpton, R. C. J. of Iowa State Med. Soc. 31:433. 1941	1	9 mos.	Sulfapyradine 73 grs. 48 grs. (some vomited) Sulfathiazole 336 gms. Sulfathiazole Sod. Sesquihydrate in 0.5% sol. intrathecally 40 c.c.	3 days 2 days 14 days 8 days	?	1.9 mgs. %	?	Positive for B. Influenzae		Discharged cured after 35 days of treatment	
Noone & Kennedy J. A. M. A. 115:2060, 1940	1	5 yrs.	Sulfathiazole 26.75 gms. Sulfapyradine 13.75 gms. Sod. Sulfapyradine i.v. 1.5 gms.	7 days 5 days 1 day	6 mgs. % on 6th day		Negative	Positive for 4 days Negative on 5th day	20,000 units meningococcic antitoxin i.v.	Recovered	Preceded by head injury

Table IV

Summary of Cases Treated with Mixed Chemotherapy

Reference	No. Cases Reported	Age of Patient	Drug and Amount	No. Days Drug Administered	Drug Level in Blood	Drug Level in Spinal Fluid	Blood Culture	Spinal Fluid Culture	Specific Serum	Result	Comment
Neal et al.	12	5 yrs.	Sulfapyradine Sulfanilamide	?					Serum	Recovered	Otitis, mastoiditis
		1⅝ yrs.	Sulfanilamide Sulfapyradine	?			Positive		Serum i.m.	Died	Necropsy: diffuse meningitis. Temporal lobe abscess
		16 yrs.	Azosulfamide Sulfapyradine	?			Negative		Serum	Recovered	
		2½ yrs.	Sulfanilamide Sulfapyradine	?			Negative			Died	Followed operation on palate
		7 yrs.	Sulfanilamide Azosulfamide Sulfapyradine Sod. Sulfapyradine	?			Positive		Serum	Died	Upper respiratory infection
		51 yrs.	Sulfanilamide Azosulfamide Sulfapyradine Sod. Sulfapyradine				Negative		Serum	Recovered	
		2¼ yrs.	Azosulfamide Sulfapyradine				Positive		Rabbit serum i. sp.	Died	Upper respiratory infection; otitis
		4 yrs.	Azosulfamide Sulfapyradine				Negative			Recovered	Mastoiditis
		1 yr.	Sulfanilamide Azosulfamide Sulfapyradine				Negative		Serum i.v. and i.sp.	Died	Necropsy: diffuse meningitis; block
		3 yrs.	Sulfanilamide Sulfapyradine Sod. Sulfapyradine				Positive		Serum i.sp.	Recovered	
		3 yrs.	Sulfanilamide Sulfapyradine Sod. Sulfapyradine				Negative		Serum i.sp.	Died	
		8 yrs.	Sulfapyradine p.o. Sod. Sulfapyradine Sulfamethylthiazole				Positive		Serum i.sp.	Recovered	
Lindsay et al.	3		Sulfanilamide Sulfapyradine						Serum and human complement	One recovery Two deaths	No details
Wilson	1	22 mos.	Neoprontosil 108 c.c. Sulfathiazole 208.8 grs. Sulfapyradine 92.4 gms. Neoprontosil ? 396 c.c.	8 days 4 days 4 days ? 22 days				Positive	Anti Influenzal serum 100 mgs.	Recovery after 35 days	Large part of sulfathiazole and sulfapyradine lost by vomiting
Neter, E.	13	3 mos. to	Sulfanilamide Sulfapyradine						Serum in	All died	No details

Discussion

Reviews of the literature by Fothergill[1] revealed that there was about 95% mortality rate from Pfeiffer Bacillus meningitis before immune serum or sulfonamide drugs were available. Silverthorne, Fraser and Snelling[2] reported a mortality of 84.6% with the use of immune serum alone.

An analysis of the data in Table I reveals that the mortality in reported cases treated with Sulfanilamide or Sulfanilamide forming drugs alone was 60% and with Sulfanilamide in conjunction with serum it was 64.3%. When Sulfapyradine was used alone the mortality rate was 52.9% and it was also 52.9% when Sulfapyradine was used with immune serum.

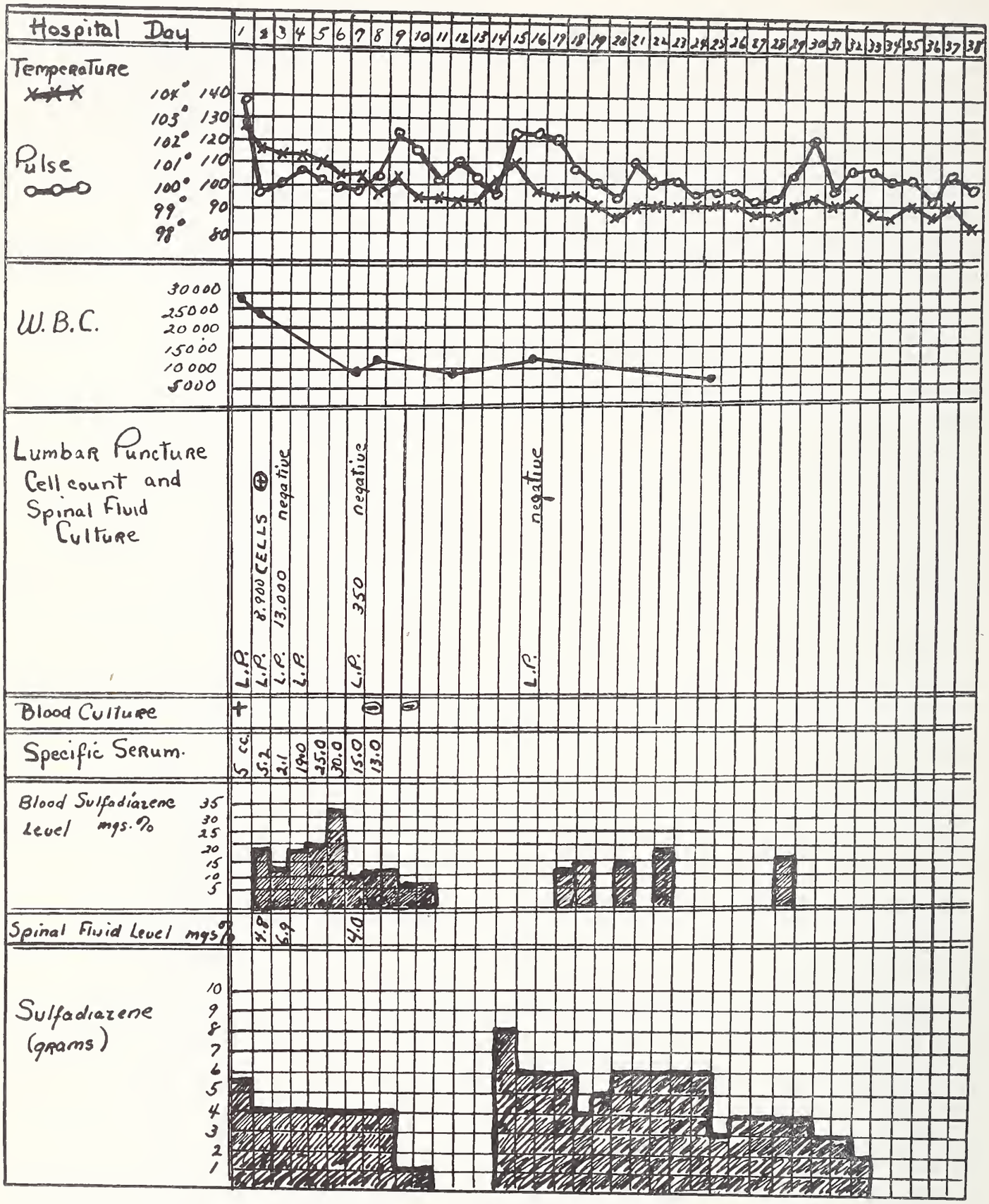
The mortality in infants under one year of age, regardless of the type of therapy used was 100% with the exception of one case treated with Sulfathiazole. This is in peculiar agreement with the high mortality rate for pneumococcus meningitis in infants under one year of age, as shown by Steele and Gottlieb[3] in a recent review of the literature.

Any attempt at a further, more critical analysis of the data in Tables I and II is practically useless because of the tragic absence of such essential data as blood and spinal fluid drug levels in such a high percentage of case reports. Previous experience has shown that Sulfapyradine is a drug notorious for its variability in absorbability from the gastrointestinal tract and in its rate of excretion from the body. Consequently, it may well be that some of the failures with this drug may have been the result of inadequate concentration of the drug in the blood stream and spinal fluid. Data concerning concentration of the drug in the spinal fluid was included only in three cases out of a total of fifty-one cases treated with Sulfapyradine. Consequently, it would seem necessary to treat another series of cases with sufficient Sulfapyradine to give adequate blood and spinal concentrations of this drug before one could be certain that the 53% of failures were due to inadequate dosage of this Sulfonamide or to failure of the drug to cure Pfeiffer Bacillus meningitis.

On the other hand, despite absence of data concerning the Sulfanilamide level in the blood and spinal fluid in 31 cases, it is well known that this Sulfonamide is quickly absorbed from the intestinal tract into the blood and spinal fluid. It would appear that adequate amounts of the drug, according to age, had been administered in the majority of the cases reported in Table I. Therefore, it would seem probable that the drug concentration in the spinal fluid was adequate in the majority of the cases treated and that the high mortality rate could be fairly attributed to failure of Sulfanilamide to inhibit the growth of the Pfeiffer Bacillus on the meninges.

Blood culture data was not given with most of the case reports. A perusal of Tables I and II will reveal that only one of the patients known to have had a positive blood culture recovered. It seems probable that the mortality rate is higher when there is an accompanying bacteremia but blood culture data was lacking in such a high percentage of the cases that statistical data was of no real value. The author did not attempt a detailed review of the serum treated cases but it was his impression that there was often a temporary improvement in the clinical chart, only to be followed in about a week by a relapse. Recovery of one case of Pfeiffer Bacillus meningitis, following use of a new drug like Sulfadiazene is of no statistical value, of course. The author has recorded this case report in order that it may be included with any other cases of Pfeiffer Bacillus meningitis treated with Sulfadiazene.

From the data now available, it would seem that immune serum, Sulfanilamide and Sulfapyradine have all failed to give the hoped for drop in mortality rate from Pfeiffer Bacillus meningitis. Consequently, it was decided to try Sulfadiazene, as preliminary reports from its use in the treatment of meningococcus meningitis suggested it was superior to any of the other Sulfonamide drugs previously tried. The good results obtained would seem to justify the suggestion that a series of Pfeiffer Bacillus meningitis patients be treated with Sulfadiazene and that careful blood and spinal fluid concentration determinations be made. It is only by tabulating and analyzing such data on a series of cases adequately treated with each of the Sulfonamide drugs that the ideal therapeutic agent can be decided upon. A striking



improvement in the clinical chart did not occur in the case here reported until five days after immune serum was begun. This observation suggests that the ideal treatment is probably a combination of chemotherapy and immune serum.

Bibliography

1. Fothergill: *N. E. J. Med.*, 216:587, April, 1937.
2. Silverthorne, Fraser and Snelling: *J. Pediat.*, 10:228, Feb., 1937.
3. Steele and Gottlieb: *Archives of Internal Medicine*, 68:211 (August) 1941.

The President's Page

To the Members of the Maine Medical Association:

Our Government is encroaching on American Business. It will, and is encroaching on Medical Practice as is evidenced by the extension of the activities of the United States Public Health Service, the expansion of the Extension Service of the United States Department of Agriculture, the Medical Care Plan of the Farm Security and the closer affiliations between the Government and State Health Groups.

Since the advent of the Wagner-Murray-Dingell Bill, the Medical Profession is being watched carefully by labor unions, large corporations and also by the public generally.

We of this Generation must realize that a Reorganization of American Life is taking place, and that we are caught in the stream of so-called Progress. So what! We cannot just sit still and do nothing at this critical time; if we do, we will be left high and dry like a log in the Rear of the Drive.

Our "Craft," the keel of which was laid at Rockland on October 24th, at a meeting of the Council and Scientific Committee, when launched, must be of staunch construction, well manned, properly ballasted, with a stout rudder astern, steered by a capable helmsman, and the lookouts ahead must be keen-eyed and wide awake, in order for it to avoid the Rocks and Snags that lie ahead. We must formulate a Plan as comprehensive in scope as is humanely possible; a Plan that will best serve the interests of all the People, and at the same time, not be too objectionable to the members of the Medical Profession.

I want to congratulate Dr. McCann, a son of Maine, for his masterly talk on Prepaid Medical Care Plans, given at Rockland on October 24th.

I recommend as worthy of your perusal, Eric Johnston's article, "We Are *Not* Washed Up," in the November issue of *The Readers' Digest.*

Fraternally yours,

Oscar F. Larson, M. D.,
President, Maine Medical Association.

Editorials

Council and Scientific Committee Meet at Rockland

Hear Doctor McCann on Prepaid Medical Care Plans Vote to Hold 91st Annual Session at Sam O set Hotel, Rockland

J. C. McCann, M. D., of Worcester, Massachusetts, Chairman of the Committee on Prepaid Medical Service of the Massachusetts Medical Society, presented an instructive and interesting talk on Prepaid Medical and Surgical Care Plans at a combined meeting of the Council and Scientific Committee of the Maine Medical Association, held Sunday, October 24, 1943, at Rockland. Doctor McCann's remarks and the discussion which followed will be published in an early issue of the JOURNAL.

Your Secretary, Doctor Frederick R. Carter, presented a report of the two meetings of the New England Conference to Consider the Wagner-Murray-Dingell bill, which were held at the headquarters of the Massachusetts Medical Society in Boston, and attended by representatives of the New England Medical Societies. Proposals presented at these conferences are now being studied by a committee appointed at the second meeting held October 20th, and will be acted upon at a meeting to be held November 17th.

The Council and Scientific Committee voted to hold the Ninety-First Annual Session of the Maine Medical Association at the Sam O set Hotel, Rockland Breakwater, Maine, on the dates set at the annual summer meeting of the Council, namely June 25, 26, 27, 1944. The meeting will open officially with the First Meeting of the House of Delegates.

All members of the Council were present at this meeting with the exception of Harold S. Babcock, M. D., of Castine, Councilor, Fifth District. Forrest B. Ames, M. D., Bangor; Roland L. McKay, M. D., Augusta; and Harvey C. Bundy, M. D., Milo, members of the Scientific Committee were present; the Chairman, Eugene E. O'Donnell, M. D., Portland, was unable to attend. Guests were: Doctor McCann; Frederick T. Hill, M. D., Waterville, President, Maine Hospital Association; S. Judd Beach, M. D., Portland, Chairman of the Maine Medical Association's Committee to Survey Hospital and Medical Care, and Warren E. Kershner, M. D., Bath, committee member; Martyn A. Vickers, M. D., Bangor, member of the Penobscot County Medical Association; Mr. Paul S. Webb, Director of the Associated Hospital Service of Maine, and Mr. Walter P. Black, Enrollment Manager.

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*Why Another Bureaucracy?**

The people of the United States will shortly be asked in Congress assembled to endorse the principle of government control of the institutions and practice of medicine.

If *S.1161* is passed, physicians will step out of the direction and control of the institutions and practice of medicine, and government will step in.

Government has stepped in in many places, before. For instance, "in Ohio there are 90,000 federal employees to 25,000 state; Massachusetts there are 129,000 federal employees to 21,000 state; Pennsylvania there are 215,000 federal employees to 44,500 state; Wyoming there are 6,200 federal employees to 1,100 state."

This bureaucracy is not elected by the people, but it is paid by the people.

* Reprinted from the *New York State Journal of Medicine*, Vol. 43, No. 20, (October 15, 1943), pages 1933-34-35.

It is not responsible to the people, but it is paid by the people.

It votes regularly but does not answer for its acts at the polls.

Yet it is extending its influence and power over the peoples' lives down to the last crossroads village, hamlet and farm.[1]

Why the great rush to increase this bureaucracy, to place the now free and liberal art and science of medicine under political control?

The federal government since July, 1939, is said to have increased its *new* employees almost 50 per cent every six months. "With more than 3,000,000 civilian employees—exclusive of Army and Navy—our federal government has now more persons on the taxpayers' payroll than *the combined total of all the employees of all the 48 states plus all the employees of all the country's county and municipal government.*"[2] Of these, 55 per cent are not directly engaged in the war effort!

Now it is proposed in *S.1161* to create a huge new bureaucracy under the Surgeon General of the United States Public Health Service, who is not elected by the people, to direct and administer the public and private practice of medicine in the United States—at the taxpayers' expense, of course. Remember also that every employee has a vote as well as a weekly pay check. Remember also that the size of such an administrative bureaucracy will be enormous. For it must care for the medical needs of about 110,000,000 people. And somebody must pay for it! Why not you?

The physicians do not want to work for the government.

They want to work for the people, directly. They want to be paid by the people, directly.

They want to be responsible to the people, directly—as they have always been responsible to the people—directly.

They do not want to see our already enormously expanding and expensive bureaucracy enlarged by another enormously expensive bureaucracy set up to control and direct the medical care for 110,000,000 people. Why? Because they do not believe that it is necessary. Because they do not believe that it would improve or even maintain our standards of medical practice. Because they do not think that it would be actually in the public interest. Because they believe that it would actually increase, not lower, the cost of medical care to the people in the long run. Because they believe that politics and medicine cannot be mixed without detriment to the quality of medical care. Because they believe, and warn, that inevitably in exchange for the establishment of an expensive political bureaucracy the people will receive a steadily depreciating quality of medical service, administered by political job-holders, and implemented by a necessarily retrograde medical profession.

If it could be honestly shown that government control of the profession would produce a better quality and a freer distribution of a better quality of medical service, the medical profession would endorse it and work for it. As Thomas A. McGoldrick, President of the Medical Society of the State of New York, said in part in his address to the Third District Branch[3] at Troy, New York: "If the *medical* plans proposed by laymen in the name of Social Security will do more for the people than the present method of distribution of services—if they will reduce the death rate and prevent sickness—if the discoveries in the art and science of medicine are better promoted and applied, and educational standards more rapidly elevated, then by all means let us have them. That doctors will be regimented, their hours of work and numbers of patients controlled, their remuneration fixed for the time by a political appointee, but fluctuating with general economic business conditions, their ambitions and competitive spirit destroyed—all these are matters of no moment compared to the physical welfare of the people.

"Doctors know, however, that by such methods as are proposed in this bill the quality of medical service will be greatly lowered. They know what has happened in other countries, in increase of the time lost in sickness, in absenteeism, in advancing death rates, in a lowered standard of health, in bureaucratic influence, and in the gradual diminution in the standing and responsibility of the profession as well as in the impairment of the quality of medical service.

"Let us see what we have *now* under our present methods and which we would exchange for the new compulsory plans for people and doctors. There are many authorities who have shown that the morbidity and mortality rates in this country are better than in any other comparable country on the globe. Last year in its annual statistical bulletin the Metropolitan Life Insurance Company published the death rate for specified causes per one hundred thousand policyholders for the year 1941. It also published the statistics for the twenty-fifth year before that time. These policyholders were of all ages, between 1 and 74. They were all in the group of weekly-paying industrial business.

"Inasmuch as the company's policyholders number many millions and are distributed widely in all sections of this country, they constitute a very representative cross section of the total wage-earning population. On the accuracy and value of these figures does the company pay millions of dollars.

"In 1917, the total number of deaths from all causes per 100,000 subscribers was 1264.5, and in 1941 it was 615.5.

"Last week (September 6) the O.W.I. reported on the civilian health of the country. The report was based on data furnished by the U.S. Public Health Service, the War Manpower Commission, and the Federal Works Agency. Statistics of the U.S.P.H. Service show that the U.S. has the lowest death rate on record—10.3 per thousand. While the number of births rose two points (in 1941), the maternal mortality rate in 1942 decreased for the thirteenth consecutive year, being three deaths per thousand live babies.

"Infant mortality also has continued to drop.[4]

" 'Influenza and typhoid,' the report continued, 'normal danger points during war, were, in 1942, below the peacetime average,'

"In passing, I would mention that the report disclosed that in one year 1,469 physicians had been relocated to regions where the ratio of doctors to population was substandard. There are many factors which are explanatory of and responsible for the above results. During the last quarter of a century medicine has contributed new aids for the care of the sick, for the prevention of illness, and for the wider diffusion of all medical knowledge.

"In all departments, obstetrics, neuropsychiatry, and the others, progress rapidly continues. Many diseased parts of the body which so recently were forbidden to the surgeon now yield to his skill; the brain, the lungs, and the heart, the gastro-intestinal tract have surrendered to his power while his advancement in all branches of his art have been astounding. A very striking feature is the speed with which medical discoveries and developments are made available to doctors and patients. It was at one time thought that ten years must elapse before a real advancement was widely utilized. Through medical journals and medical meetings, through radio and press, such knowledge is now spread in months over the entire country. For the use of sulfonamides, insulin, and atabrin, even penicillin, demands were incessant before the manufacturing drug houses could produce sufficient amounts.

"These are steps in progressive science which we will surely lose in government-controlled care of the sick. Despite the support of such bills by labor organizations and by many who will gladly take something for nothing, the people, rightly informed of the benefits of present-day medicine and the dangers to them when its existence is jeopardized, will not approve. All the people are not materially blinded, as our millions of armed boys and their families attest.

"It is surprising how intelligently a rightly informed people will act. A nonmedical editor of one of our leading magazines has expressed his thought: 'What the public wants is American Medicine and at its best . . . . . Not a minimum of advice and prescription but the saving of life and health according to the excellent standards built after long and intelligent efforts to provide the utmost within human possibility. Government could never provide the ambition, the sacrifice, the complete devotion to one's fellow man as the ideal professional man has it. Nor could Government command that entire attention to the individual which is the mark of these professions.'[5]

"With our knowledge of what medicine has done and is doing for the people, individually and collectively, with our faith in that people when rightly informed, with courage to inform them and to protect them from these calamities that threaten, we may feel with confidence, that medicine, freed again of these many attacks, will proceed uninterruptedly on its real, its magnificent, purposes."

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[1] Cf.: Harry F. Byrd, U.S. Senator from Virginia. *Readers Digest*, July, 1943, pp. 36-38.

[2] *Loc. cit.*

[3] September 21, 1943.

[4] *New York Times*, September 7, 1943.

[5] *America*, August 21, 1943.

Maternal and Child Welfare

Correction

The table of drugs and recommended syrups, copied from a bulletin issued by the Academy of Pediatrics, at the end of the Maternal and Child Welfare article entitled "Notes on Pediatric Therapeutics," published in the October issue of the JOURNAL, page 203, should read as follows:

TYPE OF DRUG	RECOMMENDED SYRUPS
Saline: Chlorides, iodides, salicylates, bromides, citrates, acetates.	Syrup of Glycyrrhiza, USP. Comp. Syr. Sarsasparilla, USP. Syrup of Raspberry, NF.
Iron Salts: Ferrous Sulphate, Iron and Ammonium Citrates.	Syrup of Cinnamon, NF. Syrup of Citric Acid, USP. Syrup of Orange, USP.
Bitter Drugs: Quinine salts. Bitter alkaloids.	Syrup of Cacao, NF. Syrup of Clycyrrhiza, USP.
Acidulous or Slightly Bitter Drugs: Ephedrine salts, thiamine hydrochloride, codeine salts, atropine, syrup hydriotic acid.	Syrup of Cherry, NF.

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*A Discussion and Case Report on Myasthenia Gravis—**Continued from page 211*

CONCLUSION

The most satisfactory results were obtained in a case of myasthenia gravis by prostigmin medication. It is suggested to keep in mind the diagnosis of myasthenia gravis whenever a patient presents symptoms of weakness, or a "run-down condition." Of course, if the patient has the classical symptoms of myasthenia gravis, like the patient here described, he should be given prostigmin at once.

1. Mechanism of Fatigue in Neuropsychiatric Patients. *J. A. M. A.*, February 20, 1943. S. A. Porter and J. H. Zitman.

2. Lester M. Levy Medical Record Myasthenia Gravis. April, 1940.

3. The Use of Prostigmine in the Treatment of Poliomyelitis. *J. A. M. A.*, August 7, 1943. Herman Kabat, M. D., and Miland E. Knapp, M. D., Minneapolis, and Subjective Reaction to Prostigmine in Treatment of Poliomyelitis. *J. A. M. A.*, September 4, 1943. George Geyerhahn, M. D., South Portland 7, Maine.

Necrologies

Edward Sewall Abbott, M. D.,

1863-1943

Edward Sewall Abbott, M. D., 80, practicing physician in Bridgton, Maine, and surrounding towns since 1885 died at his home Tuesday, October 12, 1943.

Born in Dexter, Maine, July 22, 1863, the son of Milton L., and Julia P. Sewall Abbott, he attended the public schools in Dexter, was graduated from the University of Maine, and received his medical degree from Hahnemann Medical College, Chicago, in 1885. He practiced a short time in Litchfield, Minnesota, before coming to Bridgton.

Doctor Abbott was prominent in civic affairs, being a former President of the Bridgton National Bank and Director of the Bridgton Savings Bank, for many years President of the Bridgton Library Association, an active worker and President of the Northern Cumberland Memorial Hospital, and many times health officer of the town.

He was a member and Past President of the Cumberland County Medical Association, a member of the Maine Medical Association, the American Medical Association, and the New England Obstetrical and Gynecological Society. He had also served as President of the Oxford County Medical Society. At the June, 1935, annual session of the Maine Medical Association, he was presented with the association's gold medal in recognition of fifty years in the practice of medicine.

Surviving are two daughters, Mrs. Charlotte Norton and Mrs. Gladys Chapman, several grandchildren and a great grandson, all of Glen Falls, N. Y.

James Deering Nutting, M. D.,

1875-1943

James Deering Nutter, M. D., 68, for forty years a practicing physician in Hallowell, Maine, died Sunday, October 24, 1943, in the Maine General Hospital, Portland, after a brief illness.

Born February 11, 1875, at Hallowell, the son of James Deering and Harriet Andrews Nutting, he was graduated from the Hallowell Public Schools and Bridgton Academy. He attended Bowdoin Medical School, Gross Medical School, Denver, Colorado, and received his medical degree from Johns Hopkins University in 1903.

Doctor Nutting was very prominent in civic affairs in Hallowell being chairman of the school board for several years, a trustee of the Hubbard Free Library, trustee of the Old South Congregational Church, and chairman of the Republican City Committee at the time of his death.

He was for many years a member of the Kennebec County Medical Association, the Maine Medical Association and the American Medical Association.

Surviving besides his widow, the former Edith J. Harrington, are two daughters, Mrs. Osmond R. Strong, Concord, N. H., and Elizabeth Nutting of Hallowell, and one granddaughter, Judith Nutting Strong.

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County News and Notes

Kennebec

A meeting of the Kennebec County Medical Association was held at the Veterans' Administration Facility Hospital, Togus, Maine, on October 21, 1943. The clinical program presented by the Staff of the Hospital at Togus at 5.30 P. M. was interesting as well as instructive.

After supper which was served at 6.30 P. M., a business meeting was held.

The minutes of the joint meeting of the Kennebec and Somerset County Medical Associations on April 15, 1943, was read and approved.

Dr. H. E. Small, formerly from Fort Fairfield, Aroostook County, transferred his membership from the Medical Society in that county to the Kennebec County Society and he was declared a member of this society.

A letter received and read by the Secretary of this Society outlining the action taken by the House of Delegates of the Maine Medical Association held at Augusta, June 20, 1943, raised the State dues for each member from $8.00 to $12.00. Thus it becomes necessary to collect $12.00 plus the $3.00 county dues for the coming year.

The Staff of the Soldiers' Home was thanked for the hospitality shown the society.

Three guests were introduced; Dr. Frederick R. Carter, Secretary of the Maine Medical Association, who spoke briefly on the Wagner-Murray-Dingell Bill before Congress at this time, and concerning the Rehabilitation Program; Dr. George Young of Somerset County Medical Association, who brought greetings from his county; and Lieutenant-Colonel William Mansfield, who, after being introduced by Dr. Thomas C. McCoy, gave the address of the evening. His subject was "Experiences in the Southwest Pacific with Special Emphasis on Army Medical Work." In discussing his subject Colonel Mansfield drew freely from his rich store of experiences and made his talk profitable and informative. Many questions were asked during the discussion period and the opinion was expressed that the address was well worth while.

It was decided to accept Dr. Forrest Tyson's invitation to the Association to hold the December, or annual meeting, at the State Hospital, Augusta, Maine, the second Wednesday in December, December 8th, 1943.

There were thirty-one members and guests present.

CLAIR S. BAUMAN, M. D.,
Secretary.

Washington

A meeting of the Washington County Medical Society was held at Machias, Maine, on September 30, 1943. Dinner was served at 7.00 P. M., after which the regular meeting was called to order by the vice president, Dr. James C. Bates of Eastport. The name of Dr. Austin Longfellow of Machias was placed before the board of Censors for membership in the society.

Following the business meeting, Bill S. 1161 was discussed at length. Each member of the society was urged to write a letter expressing his views to the secretary. From these letters, the secretary will compile a letter and forward it to the secretary of the Maine Medical Association.

The meeting was adjourned at 10.00 P. M. Eight members were present.

ALLEN H. KNAPP, M. D.,
Secretary.

New Members

Aroostook

Romeo Levesque, M. D., Frenchville, Maine.

Kennebec

Harold E. Small, M. D., 31 Grove Street, Augusta, Maine (By transfer from the Aroostook County Medical Society).

Proceedings

MAINE MEDICAL ASSOCIATION

House of Delegates

AUGUSTA, MAINE ❦ JUNE 20, 1943

Continued from the October Issue of the Journal, page 208

(Continuation of discussion relative to the Venereal Disease Report Law passed at the last session of the Maine Legislature)

DR. STANWOOD: I fail to see any defect in the previous law as it stood on our books.

Under the present law, in case the patient refuses or does not take the treatment, we have a form to sign that patient in as a delinquent. That patient certainly should be reported to the State; he might be in an infectious state. I think that that was the ideal law, and I have been sorrowful that it was changed. It certainly is the delinquent patient that should be followed up and not the patient who is taking his treatments regularly.

DR. CARSWELL: Mr. President, I am going to speak for the last time, I hope. I heartily endorse Dr. Stanwood's words with one addition, and that is, that the old law as it stood, I felt was adequate except that it had no teeth in it that would enable a law enforcement agency or any agency to force treatment on an individual who refused treatment. I am definitely opposed to the new law, but I do believe that the patient who refuses treatment should be forced to take treatment.

DR. HOLT: This is my last appearance. I assume that the names and addresses are in the clinics, are they not; that is, in the clinic records?

DR. STANWOOD: They are, absolutely.

DR. HOLT: Then we probably can assume they are just as safe in the State Board of Health Records. It is just a matter of keeping a few more records; that is all it amounts to, isn't it, Dr. Mitchell?

DR. MITCHELL: Yes.

DR. STANWOOD: A point has been made about the publicity of the thing. That is very apt to cramp the whole program, in my opinion.

DR. MITCHELL: May I say a word about the publicity of the thing? These records are not public. Any report that is made to the State Bureau of Health is absolutely confidential. Those records are kept in our files, and no one, except the persons who are working on the records, is allowed access to them in any way.

DR. STANWOOD: But the patients don't know that.

DR. MITCHELL: That applies absolutely to any employee of the Bureau of Public Health; they cannot let any information get out.

DR. SMITH: Does that name go back to the Health Officer of the town from which the name is reported?

DR. MITCHELL: If he is a full-time Medical Health Officer.

A MEMBER: There are a good many Health Officers who are not doctors.

DR. MITCHELL: They only go to the full-time Health Officers who are physicians.

A MEMBER: Then they are not sent to the laymen?

DR. MITCHELL: No; they are not.

A MEMBER: But the nurse gets the names to follow them up, doesn't she?

DR. MITCHELL: The District Nurse is an agent of the Bureau of Public Health and does some of its investigations. She would be in a bad fix if she gave out any names.

DR. KERSHNER: May I ask a question of Dr. Mitchell? In sending the blood in, is it sufficient to report that the patient has a positive blood, or do you want the diagnosis of syphilis?

DR. MITCHELL: We don't want to know particularly whether that patient has a positive blood; we want to know the diagnosis, and whether it is a case of syphilis. We know that sometimes a patient has a positive blood and hasn't syphilis. It is up to the doctor to study the case and have enough bloods to find out whether it is syphilis.

A MEMBER: It seems to me that this procedure places the doctor in an unpleasant position, and what happens? Some one gets in touch with the person, let us say, who is supposed to be a contact. Then the question is asked: "How do you know I am a contact?" Now, I would like to know what happens in that case. It seems to me the doctor would be in a bad jam.

DR. MITCHELL: By contact in venereal disease, we mean a person with whom that person has had sexual intercourse, and there is no information that goes out to anybody from us as to where we get our information. The source of our information is secret.

DR. LAUGHLIN: Dr. Carswell asked a question a few moments ago about these cases that are still infectious and wandering around. Well, now, if he reports that to the State Bureau of Health, then under this new law, we can take that person and explain the facts and we can take action of forcing them in for treatment. If a person will not be treated, then we can quarantine that person.

Of course, that was one problem we were up

against under the old law. We had no teeth in the old law. But under the new law, we can do something about it. And about contacts, on the form that the doctors make out, there is one question: Should this case be investigated?

Now, the doctor can answer "yes" or "no" to that. We have a lot of them who say "yes." For example, I get a lot from the Army men. That is what our nurses are investigating. When our nurses go out into the field, they don't go and accuse any one of having anything. They say that it has been reported to us, and that we have reason to believe such-and-such, and that we are just investigating because the law requires it; we are investigating whether or not you have been in contact with so-and-so; he has a venereal disease. If the woman denies it, then we try to find out the facts. And I want to say that we find some of these cases where there is no ground at all. . . .

Now, I just want to say that we try to be very careful in all of our investigations. We get a lot of reports and I know that in my district I look many of them up myself. We get some reports from the war industries where they have a physical and I see the doctor in that plant. I get him to ask the fellow questions. If this man goes under treatment, then I go to see the physician who is treating him, and ask him to try to get the man's wife to come in, too. Usually, it happens that he has a wife and several children.

Of course, what we are trying to do is to protect the public; we are not trying to make any trouble for anybody.

I have practiced medicine, and I will say that certainly we are not trying to make any trouble for the physician. I know it is a sort of an annoyance. But, a man takes his time in making his diagnosis and reporting such cases. There is a penalty for not reporting a birth within six days, of $100.00. How many of you have been fined for that? And, take the penalty on your tuberculosis work, and on your other communicable diseases; how many of you have been fined for that? I don't think that it is the intention of the Department to make trouble for anybody. We want to cooperate, always. I do coöperate with the medical profession, and I will coöperate with them to the limit. Now, if they think that law is undemocratic with reference to the clinics, then let's change the law. I am speaking as a delegate now, and not as the Health Department. I am just telling you the other side of the story. What we are trying to do is to find the contact. I have talked with institutional heads at the different homes and the schools for girls. The school down at Hallowell is bulging, and at Skowhegan, they can't get any more in. We are trying to stop this, as well as we can. We are getting pounded from Washington and everywhere. You have read the Portland papers about conditions in Portland. We know that. We know a lot of women have come in there, and when the fleet comes in, they leave their cards and go back, and the State of Maine is getting credit for it.

Before this time, we had no teeth in the law whereby we could grab them and make them have treatment.

Dr. Johnson: The doctors feel that they are able to judge whether a case should be investigated or not, and they feel that their function is being overridden. That is, they don't discriminate between infection; latent or congenital. . . .

Dr. Laughlin: . . . I do think that what Dr. Foster has suggested in his motion is good; that the Social Hygiene Committee get hold of this matter and perhaps come to some compromise on it, but for Heaven's sake, give us a law with some teeth in it to control these active cases.

Dr. Foster: I call for the question.

Chairman Larson: You have all heard the motion of Dr. Foster's and it was duly seconded. If there is no further discussion, those in favor of the motion will please manifest by raising the hand.

The majority of hands were raised, and the motion was carried.

Chairman Larson: There is one other matter to come before us, and that is the election of a President-Elect.

Dr. Foster: Mr. Chairman, I want to take this opportunity to put in nomination a man for the position of President-Elect who has served this Association well for many years in different capacities and on different committees. He has served his own District well, and he is well known to everybody here. I am sure that he is competent and is very well capable of performing the duties pertaining to this office.

I think we need at this time to have active men carry on the work of this Association. The spirit of the House of Delegates of the A. M. A. at Chicago clearly indicates that the leaders in the profession believe that the medical associations should work harder than ever to keep their organizations together and make their work effective.

At this time, I would like to nominate Dr. Raymond Bliss of Blue Hill.

Dr. George L. Pratt, Farmington: Mr. Chairman, it gives me a great deal of pleasure to second that nomination.

Chairman Larson: Are there any other nominations?

Dr. Holt: I move that nominations cease.

This motion was duly seconded and was carried.

Chairman Larson: You have heard the motion of Dr. Foster that Dr. Raymond Bliss of Blue Hill be our next President-Elect. All those in favor will please manifest by raising the hand.

All hands were raised, and the motion was carried unanimously.

Chairman Larson: I believe it will now be necessary to elect a new Councilor in Dr. Bliss' place.

(Discussion outside the record.)

Dr. Bliss: Will the House of Delegates please accept my resignation from the Council?

A Member: I move that we accept the resignation of Dr. Bliss as Councilor in the Fifth District.

This motion was duly seconded and was carried.

To be concluded in the December Issue

Index to Advertisers

Brewing Industry Foundation	VI
Camel Cigarettes	XIII
Coca-Cola	V
Corn Products Sales Company	X
Frye Company, Geo. C.	XV
Gay Private Hospital	VIII
Hood's	IX
Hynson, Westcott & Dunning, Inc.	X
Jones' Private Sanitarium	VIII
Leighton's Hospital, Dr.	VIII
Lilly & Company, Eli	XIV
Maine Surgical Supply Co.	XVI
Mead Johnson & Company	XIX
Medical Auditing Counsel	XVI
Nestle's Milk Products, Inc.	III
Ortho Products, Inc.	XVII
Parke, Davis & Company	XII
Philip Morris & Co.	XI
Physicians Casualty Association	XV
Prentiss Loring, Son & Co.	XV
S. M. A. Corporation	XVIII
State Street Hospital	VIII
Winthrop Chemical Co., Inc.	VII
Wyeth & Brother Inc., John	II
Zemmer Company, The	229

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The Journal
of the
Maine Medical Association

Volume Thirty-four Portland, Maine, December, 1943 No. 12

*Present Day Difficulties of Medical Practice and Licensure**

Adam P. Leighton, M. D., Secretary, Maine Board of Registration in Medicine, Portland, Maine

It is my intention to discuss simply and briefly with you some of the problems and difficulties which nowadays beset us, as members and executive officers of the state examining and licensing boards. My remarks will be based, for the most part, on a consideration of the activities of the Maine State Board of Registration of Medicine, for our problems are your problems, and our difficulties are comparable to yours.

For years we have gone along serenely with our board work, satisfied indeed with our progress and the maintenance of high standards in controlling the practice of medicine in Maine. The war, however, is the true etiological factor for the "mess" in which we find ourselves today. It has been my privilege to be a member of the Maine State Board for twenty-eight years, and for the past twenty-two years I have served as its secretary and executive officer. Never in my experience has there been such an upset condition of medical affairs locally, and never before have we been faced with such an emergency as at the present time.

I have had the opportunity to observe medical practice and licensure at its best, and it is rather upsetting to view the obvious transition to the present day chaotic condition when efforts are being made to break down the high morale of the past three decades and "open wide the gates" to those who are not truly qualified, or rightfully entitled to entrance within our ranks.

The demands of the Army and Navy have stripped our communities of younger medical men, and cultists, at last, have the golden opportunity which they have coveted these many years, that they might "come in through the back door" to medicine. It is disheartening, indeed, to see the good results that have followed the insistence of high requirements for practice dragged down, and the selfish desires of the few allowed to hold sway to the end that our rights and privileges of practice have been usurped in part by this horde of pseudo-medical practitioners. It is unfortunate to see the diminution in the numbers of doctors in our cities and towns, and the lack of appreciation on the part of the public, who, know-

Presented at the Thirty-Ninth Annual Congress on Medical Education and Licensure, Feb. 16. 1943.

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ing that through patriotism and necessity, our medical men have had to give up their practices for war work, have flocked to the cultists and nonmedical men who stay at home and reap the harvest.

The invasion of our shores by foreign graduates has brought about a condition of affairs which is not really agreeable, and while it is incongruous, it is true that foreign graduates who, as noncitizens, are not available to the Army and Navy Medical Corps, grasp this opportunity to move in and do business while the native medical men do their duty at the front. It does not seem proper or right that many of these men who are citizens of countries with which we are at war should be received and accepted wholeheartedly by our citizens.

In all these years when we have striven to maintain high requirements for practice and have presented a solid front of high grade professionalism, it is discouraging to see suddenly the invasion of our state by the osteopathic profession, and the veritable practice of medicine offered to them just because of a lack of foresight and "intestinal fortitude" in a few unthinking men who "sold us out" to this crowd a decade ago. The drugless healers, the optometrists, the chiropractors and naturopaths have seized upon this moment to attempt to foist themselves upon the unsuspecting public, and by ruse or camouflage attempt to flaunt themselves as medical men. The "Simon Legree" tactics of those who steered the program of Procurement and Assignment Service in Maine put on the final touch, for while no one criticizes the plan of this organization and the necessity to equip medical men for service, it does seem to me that the high powered, haphazard recruiting of doctors has brought about a very dangerous emergency in the State of Maine.

The Maine Board of Registration of Medicine was instituted in 1895. We have six members, all of whom are medical men appointed for six-year terms by the Governor of the State. It is not a composite board. The osteopaths and chiropractors have separate boards of their own, and we have no control over these cultists except as their practice might interfere or trespass upon the rights of the medical man as defined by law. As an added duty, our medical board does license the chiropodists. We have no trouble, for the most part, with these individuals, and our law specifically restricts them from making use of the prefix, "Dr.," or the word, "Doctor," and limits them wholly to the superficial care of the feet.

Previous to the enactment of the Osteopathic Practice Act, it was believed by most of us that it was better to keep this profession separate from the medical board, and to allow them to regulate their own practice through their own board. I honestly felt that this was the proper plan, and even now I have no reason to change my idea, for I had no desire then, and have none today, to try to mix with them. It did seem to me that they could be handled best and properly outside of the medical profession, and the less we had to do with them, the better. This is a matter for argument, I know, and for the years previous to 1929 when the medical profession of Maine "sold out" to this crowd, the situation was handled most satisfactorily. With things as they are at the present time, I can understand why some feel that it would be better if they had regulation of their practice through our Medical Board with one or two osteopathic members in the set-up. A composite board of this type seems to me to put the stamp of approval on this cult, and gives the impression publicly that they are accepted by the medical profession. I have heard some of my medical friends say that this is the error, and that, in due time, we will have to take the osteopaths in with us. I hope this day never comes. I started in practice at the time of the tail-end of homeopathy and while homeopathy has merged into regular medicine and disappeared, I cannot see the parallel with osteopathy, inasmuch as the homeopaths were medical men to begin with, and only differed in the matter of dosage and medicinal treatment of the sick, while the osteopath is designated as a D. O. and from the very beginning has been classed as a drugless practitioner.

The requirements for practice in Maine are these: Two years of premedical study in an accredited college of liberal arts or an A. B. degree. The applicant must be a graduate of a Class A, recognized, reputable medi-

cal school or university having the power to award the degree of M. D. It is left with our board to decide absolutely what schools shall be accepted. Only applicants who are citizens of the United States are admitted to examinations. We have reciprocal relations with thirty-six states and endorse the certificate of the National Board of Medical Examiners after a short oral examination, this being necessary to meet the requirements of the Medical Practice Act which does not allow for endorsement of credentials other than by reciprocity. Our section of the Medical Practice Act which has to do with the revocation of licenses, I believe to be one of the strongest bits of medical law which you will find anywhere, and I invite you to read its provision. It has done much to keep our ranks free from illegality and the unwanted. We have been very fussy in our consideration of applications from individuals who are graduates of foreign medical schools. We have come to know and are able to select the high grade institutions and to reject those which are questionable.

Maine has a population of 850,000, and we have 985 physicians, doctors of medicine, in practice as of this date. It is, therefore, a large state with a comparatively small population and certainly not a plethora of medical men. If you will keep these figures in mind, you will understand the serious situation in which we find ourselves today, with our cities and towns medically undermanned and stripped of their doctors. Certain localities are tremendously overcrowded because of the influx of shipyard and other war workers. In Portland, alone, we have experienced an increase in population from 80,000 to 120,000. A year ago the American Medical Association Directory listed 165 physicians living and practicing in Portland. We have today 45 of these men in the Medical Corps of the Army or Navy. Eight on this list were interns. There are two dead, 27 inactive or retired physicians, 5 public health officials, 2 bacteriologists, 4 radiologists and 29 who are opthalmologists, dermatologists, orthopedists or in other special limited practice. We find, therefore, there are actually 48 men able to engage in active general medical, surgical and obstetrical practice in Portland. You can gather some idea of the situation by these figures. We are absolutely unable to cope satisfactorily with the situation, and it will be most disastrous if an epidemic comes our way. Our hospitals are full to overflowing, and this is true throughout the state. These institutions are woefully undermanned. Most of this has resulted from the disjointed procurement policy, and the serious dislocation of manpower has resulted in the taking away of medical care to the end that the rural areas and some of the cities of Maine are medically destitute.

Up to 1920 the State of Maine had a medical school, and it was a good one. One hundred years it flourished, and its graduates are found in every state of the Union, and for this century it furnished a large part of the state's medical profession. It was an unhappy and unfortunate moment when this school was allowed to close its doors. The Medical School, an integral part of Bowdoin College, went out of existence because the Governor at that time, the Legislature and the Trustees of Bowdoin College were unwilling to put forth the effort to procure the money necessary to enlarge its plant and to permit of full time teachers, thereby embracing the plan incorporated in the Flexner report of the Carnegie Foundation for Advancement of Medical Teaching. When help was not forthcoming, it seemed better that the school should go out of business as a Class A institution rather than to slide backwards in its classification. That year was, indeed, the start of many of our present day difficulties.

The rural districts usually supplied by Bowdoin Medical graduates in later years began to suffer because of the general unwillingness of the graduates of other schools in recent times to go "back to the crossroads" to practice. The man who puts in eight or ten years in procuring his medical education nowadays follows the modern trend and locates in the city where social, hospital and business opportunities naturally lure him. The men who went to war in 1917 did not return to rural practice in very large numbers, and many of these fields having been left open since that time give opportunity to the cultists to invade successfully the territory in this present day emergency.

The medical man of Maine has little reason to complain of the predicament in which he finds himself because it is he who is mostly to blame. For years the Maine Medical Association, through its chosen representatives, journeyed to the state capitol in Augusta at the time of each session of legislature and fought the attempt of the osteopaths to gain favorable legislation. Up to 1929 this cult was kept at bay, and their practice was kept well within bounds. There came into power in the Maine Medical Association a clique of members and officials of good intention, but with a decided lack of foresight, who came to the conclusion that it was useless to fight the cultists any longer. They stated that it was "beneath us." We were "too proud to fight." If the public wanted osteopaths, it was their right. There was no fear of competition. By vote of this association and through the action of its House of Delegates, it was decided that no longer would committees appear at Augusta to attempt to fight what might be adverse legislation, and so, it happened at this particular session of legislature, not one word of medical opposition was heard when the osteopathic bill was presented for hearing. Therefore, the osteopathic profession gained everything that it wanted in the way of rights of practice, and they returned home happy and eager for great things. Right here and then trouble began for all of us. The osteopaths were given the right to practice surgery and obstetrics, and to administer such drugs as are necessary for treatment in these particular branches. You can readily see that the osteopaths with their separate board now have the rights and privileges of the entire practice of medicine open to them, and they have made the most of the opportunity. With the coming of World War II and the depletion of the state of its medical practitioners, it has left the rural districts almost entirely open to them, and they have flocked to each and every village and hamlet. There have come into the State of Maine through the medium of the Osteopathic Board 230 osteopathic practitioners, so that the ratio of osteopaths to medical men today is about 1 to 4. These men tell their patients that "they are medical men as well as osteopaths." They are administering, prescribing and dispensing drugs and medicines of all kinds, and veritably hold themselves out to the public as medical practitioners under the guise of osteopathy. There are a dozen osteopathic hospitals in Maine doing a wholesale obstetrical and surgical business. The osteopaths like to do their business under the caption of "Doctor" or "Physician," and seem to try to separate themselves from the osteopathic tinge, even though the law says they must append the word, "Osteopath" to their name. They like to appear in the telephone directory listings with the M. D.'s. They make use of prescription blanks, and in every possible way endeavor to further the deception, that the public may accept them as medical practitioners.

Optometrists and chiropractors have come into Maine in large numbers. These cultists endeavor to make use of the prefix, "Dr.," and the title, "Doctor," although they know it is illegal and seem to want to get into the parade of doctors. The public fails to differentiate, and they are wont to accept optometrists as oculists, and consider the chiropractors as members of the medical profession. Naturopaths have come onto the scene in the past ten years, and the cities have an oversupply of them, all attempting to enter the medical field. Everlastingly keeping at them and threatening prosecution is the only way that our board has been able to keep them within bounds. I suppose all of the states are more or less bothered in the same manner.

Another problem has been that of the foreign medical graduate who attempts to gain licensure. This has not been the "headache" to us which most of you have encountered. As stated previously, our Medical practice Act is so worded that the medical board determines which medical school shall be considered reputable, recognized and accepted. Our rule which requires full American citizenship from each applicant has done much to simplify the proposition. I have sympathy for the individual who through no fault of his own has been thrown out of and prevented from practicing medicine in his homeland. There are many well trained, deserving and adequately educated men who have come to our shores who, naturally, desire the right to practice in this country for a

livelihood. I do not believe that we should be too easy nor should we "open our arms" and invite them in. I am well aware of the treatment accorded those of us who in the old days attempted to gain licensure in European countries. I lived in Ireland and Austria for some time, engaged in postgraduate work. We in Maine have admitted to practice very few of the foreign graduates. About half of those who have been certified by the National Board of Medical Examiners and the other half has proved by authentic credentials that they were eligible for examination. The percent of failures, however, has been fairly large. It is unfortunate that many men, American born, who have been unable to gain entrance to our medical schools, have gone abroad, and with little trouble and less expense, received their M. D. degrees and then returned to the United States. The results of their examinations have not been good. In many instances it was found that their premedical study has often been incomplete and insufficient, and that they have been given credit for partial attendance in medical schools of this country which we do not recognize, and yet, they are admitted to advanced standing in many of these foreign schools, which take their money and rush them through to a degree. The credentials presented by the foreign graduates are worthy of greater scrutiny than is often afforded them. I have seen many an imposing array of papers and certificates, supposedly translated and sworn to as true and honest, which have been patently spurious and faked. Our experience with some of these foreign graduates to whom we have granted licensure has not been entirely satisfactory. While seemingly well trained, and having passed creditable examinations, they have come into our communities and have made trouble for all concerned. Their mode of practice is not ours, and they often go "rough shod" over the rest of us. I am supremely glad that we did not let our Christian spirit get the better of us to the end that Maine became a Mecca for these men.

At the December meeting in Washington of the Federation of State Boards with the Procurement and Assignment Service Committee, an interesting and valuable discussion was had concerning the shortage of physicians in our communities, brought about by the enlistment of doctors in the Armed Services. It is very evident that the coercion and pressure exerted upon our Maine confreres resulted in the serious depletion of the ranks which is so obvious today. Something had to be done to furnish a sufficient number of men for the Army and Navy, I will admit, but now consideration must be given the civilian population and its needs in this time of stress. The plan whereby the various states, which had no provision for temporary licensure, should immediately secure legislation to allow for same, seems timely and sensible. At this moment the Maine Legislature is being asked to take action to make this possible. As long as the board has the power to determine just what men, who desire relocation for the duration, should be allowed these temporary licenses, all is well. We insist that these temporary licenses shall be given only to those who are graduates of recognized, reputable and accredited medical schools, and that they are men to whom we would allow admittance to our examinations under normal conditions. We shall not allow any unrecognized medical graduate, even though licensed in another state, to come into Maine, nor will we accept any foreign graduate, even temporarily, whose credentials otherwise would not be acceptable were he to apply for permanent registration and licensure.

In conclusion, I want to discuss briefly one of the problems of this board which probably very few of the other states have encountered. Ours is a vacation state, and summer camps for boys and girls abound in great numbers. We have over 250 of these camps on our shores, lakes and streams with an attendance of about 17,000. They are, of course, for the most part commercial propositions. For years these camps brought with them their own physicians, and though unlicensed, this was winked at for obvious reasons. A few applied for licensure, but most of them came, planning to stay for the one season, and because of the expense and bother, refrained from attempting to comply with the law. I have always held that inasmuch as the Medical Practice Act stipulates that all who prac-

Continued on page 238

Discussion of Section XI, Title IX, Social Security Act

(Delivered before Thayer Hospital Staff by A. G. Eustis, Trustee of Thayer Hospital and Treasurer of Colby College)

I appreciate your asking me to speak to you this evening. I do not, however, wish to proceed under false colors. I am not a specialist in the medical or hospital field. I am not even a man from out of town. I have read rather extensively regarding the so-called Social Security bill, of which the medical and hospital section is a part. I have observed, studied and experienced the social and economic revolution going on in this country under the New Deal. I have often heard the expression "It can't happen here" and I have seen it proven wrong in many instances.

The bill before us represents the natural outcome of the movements in the social field which have been under way for some years. It is in direct conformity with the economic principles or lack of principles now dominating our Government.

This principle can possibly be summed up in the idea that there is something basically wrong with private initiative and the profit system—big business, if successful, is a menace, hence kill off initiative and cure all by having the Government itself take over. This is in spite of long-demonstrated inability of Government to do so successfully. Our Government thinking has been dominated by highly impractical, highly intelligent individuals, almost all without practical experience and all with a blank check. With extreme reluctance and with remarkable slowness, it is becoming gradually recognized by Government that a country engaged in a desperate war must have proven ability to operate. Despite this belated recognition, I feel that there is no basic change of heart or conviction on the part of Government, but merely a marking of time. It is possible the public may have changed more. As a single illustration that no great progress has been made, I cite the Treasurer's recent tax proposals recommending lifting the entire tax burden of several million of our citizens, incidentally, that group whose incomes have been increased most during the war and incidentally the largest group of voters. Also I cannot fail to mention the craziest of all proposals—a post-war credit in the form of life insurance. Such a proposal violates basic principles of taxation as well as all principles of insurance.

The same principles which developed in economic thinking extended to the social. That it was the basic responsibility of Government to provide from cradle to grave and that the mere fact that the individual was undeserving demanded not even passing consideration. Hence the present expanded Social Security bill. However, in giving our attention specifically to the bill, it is of little use for us to beat our chests and state statistics as to how much progress has been made. It is true that with pride we can point out that the American system has produced the most effective and widely distributed medical care any people has ever known. We can point out that in the last one hundred fifty years the average number of years a man lives has nearly doubled. The average life expectancy in 1790 was 35—today it is 62. A child born in 1942 has a life expectancy twelve years longer than one born in 1900. In 1942, the United States possessed the highest general level of health and the lowest death rate ever known by a like number of people. Our medical schools are second to none. They give our people more and better trained physicians than any other people receive.

In view of this record, seemingly it could be contended that no revolution is needed. In no sense do I mean to imply that we oppose the Government entering into areas not now adequately covered and in supplementing voluntary effort along the lines of Social Security.

In referring specifically to the medical and hospital phases of the Wagner bill, it would appear that there are two things to do. First,

defeat the bill in its present form. The objectives of the bill as stated by the Surgeon General are: "We seek to enable every individual to obtain maximum physical and mental development, to have an equal opportunity for health within the limits of inherited capacity. We seek to provide the best health services, preventative and curative, for everyone. The lack of capacity to pay for services should not deprive anyone of the best. The total cost is well within the individual and collective ability of the population to pay." It is my contention that the Wagner Bill will not improve the standard of hospitalization or medical care and as now set up, would not even reach the indigent. One can very seriously challenge the statement that the Social Security program is within the capacity of the population to pay. No intelligent person could dispute the fact that the Government can go only as far as sound fiscal policy permits. It is estimated by competent authorities that the total cost of the Social Security program now being considered would be about twenty billion dollars a year—one-fifth of the entire likely National income and three times the amount spent before the war. The bill proposes three billion dollars for hospitalization and medical purposes. It places in the hands of the Surgeon General of the Public Health Service, power and authority to hire doctors and possibly all doctors at fixed salaries, provide medical service, say which doctors can be specialists, determine the number of doctors' patients, determine what hospital or clinic may serve patients. The Surgeon General, therefore, would supervise the medical care for one hundred ten million people. It is estimated that there are one hundred twenty thousand physicians in the United States available for civilian practice. The amount of money provided would be sufficient to hire all at an average salary of $5,000 a year, pay for every bed in every hospital, both public and private. All doctors could be contracted by the Government, working eight hours a day; the patient is compelled to come to them and they are compelled to serve.

I doubt that under such a system our general level of medical practice would be raised. More likely the reverse would follow. What happens to incentive? Advancement obviously would not be based on skill but if precedent can be believed, promotion would be dependent on the local democratic politician. Of course it would be only one step from this to provide higher education under a completely regimented system.

The second step must first include doing everything in our power to rebuild a foundation of confidence in the future opportunities of individual enterprises. Neither business men, nor hospitals, nor professional men of any sort can plan ahead with confidence if uncertainty exists as to the continuation of our existing economic system.

We need Government recognition of the nation's firm belief in competitive enterprise and the profit motive as the keystone of the national economic system. We are either going to have the American competitive system or the socialization of enterprise. It is one approach or the other—it cannot be both.

I must confess that freedom and complete security do not go together.

In the second place, in taking the stand in opposition to the bill under discussion, it is insufficient to rest on the laurels of the medical and hospital profession. I recall with interest the rather strong opposition expressed by many members of the profession during the early days of the Blue Cross.

Hospitals and the medical profession, more than ever before, must recognize their social obligations. We must adapt our practices and thinking to the rapidly changing world in which we live, whether we like it or not.

Every encouragement should be given to the voluntary social agencies. The prepayment principle of hospital protection now covers 17½ million people. Five million are under commercial plans and 12½ million under the Blue Cross.

The hospitals must become community centers for prevention as well as for diagnosis and cure. They must coöperate with public health authorities and with all research organizations. The idea of a hospital as merely a place to operate, bed and board a patient is gone. Let us proceed to cure our own ills by trial and error, or bureaucratic reformers will do it for us.

We should encourage and support federal and state subsidy for that segment of our population actually unable to bear the burden.

We should encourage low-cost plans for medical and hospital care for those who cannot pay. We must encourage groups of physicians working together and organized around the hospital staff.

We believe in social medicine but voluntarily and freely undertaken by people and doctors working together and learning by their own experience.

Present Day Difficulties of Medical Practice and Licensure—Continued from page 235

tice medicine for gain or hire within the boundaries of Maine must be licensed, this certainly applied to the camp physicians. Therefore, I have exacted registration or licensure in each instance. The camp owners recently demurred from paying the fees for reciprocity or examination, and inasmuch as it became increasingly hard to get medical men to serve as camp physicians on account of our restrictions, the Camp Owners' Association recently came to us and asked for some means of temporary licensure. This legislation, now pending, will allow, when passed, that a camp doctor may have a temporary license for the payment of $10 after fully satisfying the board that he is acceptable. This will give him the right to practice in these camps for ten weeks in the summer, the license being good for that one season alone. He must abide by the medical laws of the state of Maine, and he cannot practice outside of the camp where he is hired, or hold himself out as a medical practitioner in the villages and towns adjacent to said camp. I feel that this will solve the difficulties of the camping problem and its medical attendants. It will certainly be a medicolegal safeguard, and it will keep this physician where he belongs, in the camp. Heretofore, it has not been a fair proposition, as physicians, ostensibly camp physicians, have gone out into the nearby villages and towns and attended patients. The regular licensed physician suffered by this competition at the time of year when the opportunity was his and at hand for a remunerative practice.

We who have to do with the examining and licensure of physicians must realize that we cannot afford to allow any relaxation in the vigilant attention which we have given, and must continue to give, to the protection of the public and the profession, in these war days. There are too many trying to break down the barriers, and in their selfish desire they will stop at nothing to attain their ends. We must be watchful of our right and privileges as medical men. In Maine we intend to do this very thing.

Excerpt from "The Role of the Cancer Clinic in Cancer Control," by Bowman C. Crowell, M. D., from "Radiology," June, 1943

"Today's universal preoccupation with the war should not be allowed to retard the cancer control program. Conservation of manpower for war industries and civilian defense constitutes an integral part of the nation's planning, and the object of cancer control is such conservation. It has been abundantly proved that, as Doctor Hektoen has pointed out, cancer is the most curable of all the diseases that are listed among the major causes of death. This presupposes, of course, that cases reach the physician and are accurately diagnosed and adequately treated in the early stages of the disease. I have previously drawn attention to the fact that, at present mortality rates, one and a half million persons will die from cancer within the next ten years in the United States. Surely no effort to reduce those rates should be spared. Concretely, military service has deprived a number of cancer clinics of their key men. It is our hope that the framework of the clinics will be maintained by those who remain behind, and that the ground gained by many years of effort will not be abandoned to the enemy."

The President's Page

In the Present Emergency

Keeping the people in the best possible state of health should be the major effort of every physician. The fact that many young, vigorous, highly trained medical men have been taken into the various armed forces leaves the civilian population short of physicians and surgeons. This being the case, proposals for the relaxation of our existing State Medical laws will undoubtedly be advocated.

In this state, the matter has been, and is being, very capably handled by the Board of Registration of Medicine. If it was not for this barrier we would be overrun by a horde of miracle mongers and charlatans.

To let the bars down at this time might give the people more treatment, but of what kind, may I ask. In fact it would be a calamity, for poor treatment many times is worse than no treatment at all; also it would be a very poor reward for those patriotic young men, who in this emergency have already offered their skill to the armed forces of this country, to find on their return that the field to which they have given the best years of their lives, has been turned into a happy hunting ground for quacks.

Doctors are not "Super Men," but I believe that it takes considerably better than average intelligence to meet the exacting requirements of modern medical training. Besides a good mind, a doctor must have qualities that set him apart and entitle him to the unqualified confidence of the public. In fact, men without character, courage and perseverance can not stand the gruelling strain of modern medical education, which, in itself, is a proving ground for their future strenuous lives.

To such men only can we afford in either peace or war to entrust the health of our state and nation.

Oscar F. Larson, M. D.,
President, Maine Medical Association.

Open Letter

The open letter, which follows, was drawn up and approved by the New England Conference, consisting of representatives from the New England State Medical Societies, following a careful study of the Wagner-Murray-Dingell Social Security Plan (Senate Bill 1161 and House Bill 2861) now before the Congress of the United States, and by the Council of the Maine Medical Association. This letter has been sent by each of the New England State Medical Societies to their respective representatives in the Congress of the United States, and was released to the Associated Press and local papers for publication on December 3rd, and to the Radio.

Frederick R. Carter, M. D.,
Secretary.

Dear Sir:

The Maine Medical Association, in conjunction with the Medical Societies of New Hampshire, Vermont, Massachusetts, Rhode Island and Connecticut, has studied Senate Bill 1161 and House Bill 2861 now before the Congress of the United States and respectfully submits its views on this proposed legislation.

We approve of the broad medical objective of the Act that we interpret to be an attempt to improve the health of our people. As a basis of our approval we cite the progressive leadership which the physicians of New England have always shown in the development of public health enterprises. For more than fifty years we have consistently supported the plea for the establishment of a National Department of Health with a Secretary in the President's Cabinet, under whom would be coördinated many important public health programs, exclusive of the Army and Navy. These are now scattered through various departments and bureaus of the Federal government and already play a large role in the provision of medical care for the people of this country.

We approve of the use of the insurance principle on a voluntary basis as a means to aid the individual to budget against the cost of medical care. We maintain that when insurance programs are not directly under the supervision of the medical profession by whom medical care is to be rendered, they should provide for cash benefits to be paid to the individual, for we firmly believe that the citizens of New England are capable of using cash benefits to pay the costs of medical care.

We believe that S. 1161 and H. 2861 do not provide for the sound development of a National Health program. It is implied by the Act that the distribution of compulsory savings managed by Federal authorities will guarantee better health for all of the people. We sincerely doubt that such an objective can be realized in this way. In the New England States, judged by any standards with which we are familiar, there is no need to revolutionize the habits of the people in their methods of obtaining medical care.

Private enterprises in the field of voluntary prepaid medical and hospital insurance are increasing rapidly. These Facilities Should be Utilized by the States, if Necessary Through Federal Grants-in-Aid, so That Each State Can Purchase Medical Care for Those Who Cannot Purchase it for Themselves. This we believe to be a development that would be acceptable to the New England people, for thereby medical care could be provided even for the indigent, who are public charges, a provision most desirable in those communities that have been unable or unwilling to meet this obvious responsibility.

We shall be glad to work out plans with representatives of the Federal and State governments to improve the health of all the people, but we should expect that any plans that might be devised would take full advantage of existing agencies and be developed within the social patterns that are well understood by our people.

Very truly yours,

Oscar F. Larson, M. D.,
President.

Frederick R. Carter, M. D.,
Secretary.

Editorial

Penicillin Research Committee Issues First Clinical Report

It Is a Remarkably Potent Antibacterial Agent, National Research Council Group Declares from Study of 500 Cases

Penicillin is a remarkably potent antibacterial agent which can be given by injection into a vein (intravenously), into a muscle (intramuscularly) or by local application but is ineffective when given by mouth, the Committee on Chemotherapeutic and Other Agents, of the Division of Medical Sciences, National Research Council, declares in *The Journal of the American Medical Association* for August 28 in a statement outlining the findings from a study of 500 cases of infection treated with the substance. The committee is composed of Chester S. Keefer, M. D., Boston, chairman; Francis G. Blake, M. D., New Haven, Conn.; E. Kennerly Marshall, Jr., M. D., Baltimore; John S. Lockwood, M. D., Philadelphia, and W. Barry Wood, Jr., M. D., Baltimore.

Other conclusions from the study reported by the committee are that following intravenous or intramuscular injection penicillin is excreted rapidly in the urine, "so that in order to obtain an adequate amount of potent material in the circulating blood and tissues it is necessary to inject penicillin continuously or at frequent intervals; that is, every three to four hours.

"Penicillin has been found to be most effective in the treatment of staphylococcic, gonococcic, pneumococcic and hemolytic [blood destroying] streptococcus infections. It has been disappointing in the treatment of bacterial endocarditis [inflammation of the membrane lining of the heart]. Its effect is particularly striking in sulfonamide resistant gonococcic infections.

"While the dosage schedule requires additional investigation, it seems clear that the average patient requiring intravenous or intramuscular injections for serious staphylococcic infections requires a total of between 500,000 and 1,000,000 Oxford units, and the best results have been observed when treatment is continued for at least ten days to two weeks. At least 10,000 units should be given every two to three hours at the beginning of treatment, either by continuous intravenous injection or by interrupted intravenous or intramuscular injections.

"Satisfactory results are obtained in sulfonamide resistant cases of gonorrhea following the injection of 100,000 to 160,000 units over a period of forty-eight hours.

"Patients with pneumococcic pneumonia frequently recover following the use of 100,000 units given over a period of three days. This is especially important in sulfonamide resistant pneumococcic infections. . . .

"Toxic effects are extremely rare. Occasional chills with fever, or headache and flushing of the face have been noted. . . ."

The Oxford unit, so called because the first extensive work on penicillin was done at Oxford University, England, is that amount of penicillin from a particular batch which will destroy a given number of Staphylococcus aureus (pus producing organisms). Different batches of penicillin vary in the number of Oxford units they contain. In the September issue of *Hygeia, The Health Magazine,* E. K. Gubin, Washington, D. C., explains that 160 quarts of mold culture will yield 10 grams of penicillin, which is sufficient for about one hundred standard doses and that it has been estimated that under present manufacturing conditions 1,000 grams of penicillin would cost nearly $50,000 to produce.

The report of the committee is based on the studies conducted by twenty-two groups of investigators accredited to the committee. As has been pointed out in recent announcements, the amount of penicillin that can be

produced is not sufficient fully to meet the needs of the armed forces, thus little, if any, of the substance is likely to be available for civilian use for some time.

The committee says that since the question of adequate or optimum dosage of penicillin has not been clearly defined, the objective in treatment should be the maintenance of a sufficient concentration of penicillin in the blood to inhibit completely the growth of the individual infecting organism.

The committee points out that the reason that the substance is ineffective when given by mouth is that investigators have shown that the gastric juice destroys penicillin rapidly at body temperature, the destructive action appearing to be due to hydrochloric acid.

Of particular importance is the declaration of the committee regarding strains of various organisms that are resistant to penicillin. The committee says that "It is of considerable interest that penicillin fast strains of pneumococci are susceptible to the sulfonamides and that sulfonamide resistant strains of pneumococci are susceptible to penicillin. Moreover, C. M. McKee and C. L. Houck have shown that an increase in the resistance of organisms to penicillin is associated with a proportional loss of virulence, an observation that is in striking contrast to the retention of virulence by sulfonamide resistant cultures.

"Obviously, more information is needed concerning penicillin resistant strains and their mode of production, since it may aid one in interpreting the clinical results or failure. . . ."

Regarding the results of treatment of Staphylococcus aureus infections with bacteremia (infection of the blood stream), the committee says that 60 per cent of 91 patients recovered or improved under treatment so that recovery followed later. Death occurred in 37 per cent and no effect was observed in 3 per cent.

"In a group of such infections in which the fatality rate is so high," the committee says, "these results are very impressive, since the over-all fatality rate in this group without penicillin or sulfonamides is usually about 85 per cent. . . . The failures only serve to emphasize the great importance of early diagnosis and immediate and adequate treatment. . . ."

Of 55 patients with osteomyelitis (inflammation of the bone marrow or the bone and marrow) 48 recovered or improved and 7 showed no effect. However, it is pointed out by the committee that final statements concerning the ultimate outcome of these cases cannot be made until several years have passed.

Of 129 cases of gonococcic infection, all of which were sulfonamide resistant, 125 were free from symptoms and were bacteriologically negative within nine to forty-eight hours after treatment. These findings lead the committee to declare that "Here, then, is a most potent weapon in the treatment of sulfonamide resistant gonorrhea, and it is not too much to predict that penicillin will prove to be one of the most effective agents in the treatment of a disease that causes great ineffectiveness in the armed forces and in the civilian population."

The Purposes and Functioning of the Council on Medical Service and Public Relations of the American Medical Association

The Council was authorized by the House of Delegates of the American Medical Association at its annual session in Chicago in June, 1943. The members of the Council were immediately appointed by the Board of Trustees. Section 4 of Chapter IX of the By-Laws provides that the duties of the Council shall be as follows:

"(1) To make available facts, data and medical opinions with respect to timely and adequate rendition of medical care to the American people;

"(2) to inform the constituent associations and component societies of proposed changes affecting medical care in the nation;

"(3) to inform constituent associations and component societies regarding the activities of the Council;

"(4) to investigate matters pertaining to the economic, social, and similar aspects of medical care for all the people;

"(5) to study and suggest means for the distribution of medical services to the public consistent with the principles adopted by the House of Delegates, and

"(6) to develop and assist committees on medical service and public relations originating within the constituent associations and component societies of the American Medical Association.

"In the exercise of its functions, this Council, with the coöperation of the Board of Trustees, shall utilize the functions and personnel of the Bureau of Legal Medicine and Legislation, the Bureau of Medical Economics and the Department of Public Relations in the Headquarters Office."

The Council is also bound by the actions of the House of Delegates on the subject of medical care and its distribution, notably the platform adopted in 1937 as amended and amplified in subsequent years by the various resolutions and reference committee reports adopted by the House of Delegates.

In order to carry out these functions, the Council has organized as follows:

Organization

Officers. — The Council shall elect annually:

A chairman.

A vice-chairman.

A full-time secretary.

An executive committee of three shall be created, which shall include the Chairman, the Council member of the Board of Trustees, and a third member to be chosen annually from the duly appointed or elected members of the Council on Medical Service and Public Relations. This committee shall exercise such functions as are delegated to it by the Council.

The central office of the Council is to be located in the office building of the American Medical Association in Chicago, Illinois.

The functions of the Council outlined in the By-Laws are closely integrated and cannot well be considered separately. To carry them out it is obvious that the Council must have adequate sources of information, maintain close contact with constituent associations and component societies, and establish close relationship with the already existing Bureaus and Departments of the Association.

The Council, therefore, subject to the approval of the Board of Trustees, has decided on the following methods of operation:

1. In carrying out the directive in the By-Laws as to relationship with the other Bureaus and Departments of the Association, the Council has established close collaboration (a) with the Bureau of Medical Economics, which has been asked and has expressed the willingness to do the research on many of the economic problems necessary for the Council's study, and which is well equipped to carry out such research; (b) with the Bureau of Legal Medicine and Legislation. Joint bulletins will be issued with that Bureau on legislative matters. Attempt will be made to effect wider distribution and, if necessary, more frequent publication of such bulletins; (c) with the Department of Public Relations. The Council shall utilize the sources of information of this department and joint bulletins may be issued from time to time with it, and if indicated with other bureaus of the American Medical Association. All planning will be to avoid overlapping of functions and duplication of effort.

2. The Council on Medical Service and Public Relations has extended the sources of information of the American Medical Association on problems with which the Council is specifically concerned. Through its mem-

bership and by coöperation with constituent associations and component societies and the utilization of other facilities, the Council will disseminate such information toward effecting its objectives. The Secretary of the Council, with its approval, will undertake such travel as may be necessary.

3. In order that constituent associations and component societies may be kept informed of the activities of the Council, and of proposed changes in the status of medical care, and that the Council may be of assistance to those associations and societies, the Council has requested each State Association to designate an existing committee or create a new committee to function with the Council on a State level.

Each State organization has also been requested to contact each component society in the State and ask it similarly to designate or form a committee to function in connection with the programs of the Council. Where such organization is feasible, it has been suggested that committees be created along the lines of congressional districts.

Such State and county committees have been urged to keep the Council informed of their local problems and activities.

State organizations also will be requested from time to time to conduct experiments in the various methods of medical care and to inform the Council of their results so that the Council may study and evaluate the experiments and transmit the information acquired to all concerned.

4. The Council feels that under its directive it is its duty to endeavor to evolve such modifications of our present system of medical care as may be necessary to cover all the people and be in accord with the traditions of American Medicine as to high standards of medical care and the American tradition of free enterprise as already outlined in paragraph 1 of the Council's Policies previously published. To accomplish this, study must be made of all economic, social, and similar aspects of such care.

5. In order that the above program may be effectively carried out, the Secretary of the Council, with the guidance of the Council in conformity with the above expressed relationships with other Bureaus and Departments, shall inform the profession through the various State organizations of all pending national legislation and bureau directives affecting the practice of medicine. It shall likewise be his duty with the guidance of the Council, to arrange for medical representation at meetings and hearings pertaining to medical care, collaborating in the representation with other Councils and Bureaus of the American Medical Association who have an interest in this same subject.

6. The Secretary is instructed with the supervision of the Council, and in collaboration with the Department of Public Relations, to disseminate information concerning the activities of the Council through the publications of the American Medical Association and the various state medical journals, and to prepare and release information on medical care.

The Council has already issued its Statement of General Policies, and it will act in accordance with those Policies and the above methods of functioning.

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County News and Notes

Aroostook

The fall meeting of the Aroostook County Medical Society was held at the Presque Isle Army Air Field and at the Northeastland Hotel, on October 12, 1943.

Afternoon Session: The members were guests of Major Heimstra and fellow Officers at the Base Hospital, Headquarters Building. There they were shown around the hospital in small groups, each in charge of an Officer. They were impressed by the large capacity and excellent equipment of the hospital, and by the efficient manner in which it functioned.

Supper and Business Meeting: Our Officer hosts were our guests at the supper and business meeting at the Northeastland Hotel.

President Faucher opened the business meeting with appropriate remarks and welcome to our guests. All stood for the customary minute of silence in honor of the memory of our beloved, recenty deceased member, Frederick W. Mitchell, M. D., of Houlton.

Romeo Levesque, M. D., of Frenchville, Maine, was elected to membership.

The Wagner-Murray-Dingell Bill was discussed and the Secretary was instructed to send resolutions expressing the prevalent and unanimous opinion of this Society with respect to the Bill, an opinion of distinct disapproval to our Senators and Representatives in Congress, and to the Secretaries of the Maine Medical Association and American Medical Association. A Committee of two members was appointed by the chair to check on each individual member of the Society in an effort to get each to write his own letter of protest to our three representatives in Washington.

Francois J. Faucher, M. D., and Clyde I. Swett, M. D., were elected delegates to the 1944 Annual Meeting of the Maine Medical Association. Armand Albert, M. D., and Herrick C. Kimball, M. D., alternates.

Evening Program: The group returned to the Army Air Field Base Hospital and the meeting was turned over to Major Heimstra, through whose efforts and kindness the following program was arranged.

1. Slides illustrating various phases of venereal disease, with comments by Major Bell.
2. Remarks on the North African Expedition, stressing low mortality of wounded and necessity of improvising. Capt. Canetti.
3. Expansion of Medical Corps to Wartime Needs — remarks about the adaptation of the civilian medico to army life. Major Heimstra.
4. Mental conditions in men returned from action and isolated posts—40% of returned men are N. P., most of these anxiety neurotics or constitutional psychopaths. 90% go back to civilian life and become our problem. Capt. Zeltzerman.
5. Helpful hints to general practitioners on Eye, Nose, and Throat Problems. Capt. Eadie.

President Faucher thanked Major Heimstra and his fellow hosts for an exceedingly enjoyable afternoon and evening, whereupon the meeting was adjourned to the annual meeting in Houlton next June.

There were thirty members and guests present.

THOMAS G. HARVEY, M. D.,
Secretary.

Penobscot

The annual meeting of the Penobscot County Medical Association was held at the Bangor House on Tuesday, November 16, 1943.

The usual business meeting was held, with reports of the Secretary and Treasurer.

Leonard H. Ford, M. D., of Bangor, was elected to membership. Dr. Ford has retired from the armed forces with the rank of Colonel.

Officers for 1944 were elected as follows:

President, M. C. Moulton, M. D., Bangor.

Vice-President, S. S. Silsby, M. D., Bangor.

Secretary-Treasurer, F. B. Ames, M. D., Bangor.

Board of Censors: H. C. Scribner, M. D., Bangor; M. F. Ridlon, M. D., Bangor; J. J. Pearson, M. D., Old Town.

Delegates to Maine Medical Association: L. H. Smith, M. D., Winterport; S. S. Silsby, M. D., Bangor; F. D. Weymouth, M. D., Brewer; E. T. Young, M. D., Millinocket.

Alternate Delegates to Maine Medical Association: H. G. McKay, M. D., Old Town; C. E. Blaisdell, M. D., Bangor; A. C. Adams, M. D., Orono.

The speaker of the evening was Joseph F. Ross, M. D., Evans Memorial Hospital, Boston, Mass. His subject was: "Specific Indications for the Use of Blood and Plasma."

Forty-seven attended the meeting.

FORREST B. AMES, M. D.,
Secretary.

Piscataquis

The Piscataquis County Medical Society met at the New Milo Hotel, Milo, Maine, on November 18, 1943. The meeting was called to order by the President, A. M. Carde, M. D., of Milo. The minutes of the previous meeting were read and approved.

Maternity cases of Soldier's wives and the child up to one year of age was discussed by G. E. Dore, M. D., of Guilford.

It was voted that the Secretary write Congressman Fellows and Senator Brewster protesting the Wagner-Murray-Dingell bill.

The speaker of the evening was J. E. Whitworth, M. D., of Bangor, who spoke on *Vertigo*. The subject was very well presented and produced an interesting and educational question period.

H. C. BUNDY, M. D.,
Secretary.

New Members

Oxford

Roland L. McCormack, M. D., Norway, Maine.

Penobscot

Leonard H. Ford, M. D., Bangor, Maine.

Piscataquis

Stanley N. Marsh, M. D., Guilford, Maine.

Notices

Scientific Exhibit American Medical Association

The Scientific Exhibit at the Chicago Session of the American Medical Association, June 12-16, 1944, will be held at the Palmer House. Exhibits will cover all phases of medicine and the medical sciences with particular emphasis on graduate medical instruction for the physician in general practice.

Application blanks for space in the Scientific Exhibit are now available and may be obtained by communicating with the Director, Scientific Exhibit, American Medical Association, 535 N. Dearborn Street, Chicago 10, Illinois.

More Help for Milk-Allergic Patients

Appetizing and nutritious recipes for using Mull-Soy in milk-free diets are now available in a new publication of Borden's Prescription Products Division. Already widely prescribed as a hypoallergenic substitute for milk in infant formulas, Mull-Soy is now proving equally useful in diets of older infants, children and adults who are allergic to milk.

Mull-Soy is an ethically-marketed soybean food in liquid emulsified form. It is palatable, readily digestible, well-tolerated, and easy to use. Although hypoallergenic in most cases of milk allergy, it nevertheless closely resembles milk in nutritional values of protein, fat, carbohydrate, and minerals. Mull-Soy ingredients are entirely of non-animal origin, consisting of soybean flour, soybean oil, soybean lecithin, dextrose, sucrose, calcium phosphate, calcium carbonate, salt, and water. After special processing at carefully controlled temperatures, the mixture is homogenized at high pressure, sealed in sanitary-type cans, and sterilized. In flavor it is slightly sweet and nutlike, and many find it makes a pleasing warm drink when simply diluted with an equal amount of hot water.

Included in the new Mull-Soy recipe folder are numerous beverages, soups, and desserts, as well as directions for using Mull-Soy in place of milk or cream for cereals, coffee, mashed potatoes, etc. Each recipe has been carefully tested in the Borden Experimental Kitchen and checked for palatability, ease of preparation, and suitability for milk-free allergy diets. A number of the recipes have several variations and optional ingredients which permit greater variety in the diet and also make the recipes more useful for patients allergic to other foods in addition to milk.

These Mull-Soy recipe folders are designed for distribution by physicians to their patients. Any desired number of copies may be obtained by writing to Borden's Prescription Products Division, Department CB, 350 Madison Avenue, New York 17, N. Y.

Change in Casec Measurements

Casec now measures six *packed* level tablespoonfuls instead of 12 level tablespoonfuls, as formerly, so that directions to the patient should be amended accordingly. Casec is indicated in colic and loose stools in breast-fed infants, and in fermentative diarrhea, malnutrition, celiac disease and for premature infants. Mead Johnson & Company, Evansville, Indiana, U. S. A.

Proceedings

MAINE MEDICAL ASSOCIATION

House of Delegates

AUGUSTA, MAINE ❦ JUNE 20, 1943

Continued from the November Issue of the Journal, page 229

Chairman Larson: We shall now have to elect a Councilor to take the place of Dr. Bliss in the Fifth District. Nominations are now in order.

Dr. Foster: In the meantime, while the Delegates of the Fifth District are conferring, may I make a report for the Pinkham Fund. The Pinkham Fund was brought before this Association last year, with a sum of $20,000 left by the late Amy Pinkham, to be utilized, that is, the income of which was to be utilized for undernourished and tuberculous children. The will had a difficult, stormy time through the Probate Court, because of the provisions in the will. Consultations were had with Mr. Mott, who drew the will, and another lawyer in Boston, and with Judge Chaplin, the Judge of Probate in Cumberland County.

As a result of these various consultations, the following disposition was made of the fund, which disposition was satisfactory to Mr. Mott and to his legal advisor, and to the Judge. The money had to go to some established charity organization. It was, therefore, decided by the Judge of Probate, as I said, accepted by the others concerned, that the $20,000 be deposited in the Maine State Health Council or Association, as a separate fund, to be deposited in their Trustee's hands, Mr. Clark of the National Bank of Commerce, and that it be kept as a separate fund, the income of the fund to be utilized as advised and recommended by a Committee appointed by the President of the Maine Medical Association.

I have had correspondence with Colonel Stearns, who is the President of the Maine Public Health Association, and expect to have a meeting soon.

The income of the fund at present is a small item, but it is understood that the fund is to remain distinctly as a fund for the purpose for which it was intended, and the income of the fund will be appropriated and utilized on the advice of the Committee appointed by the Maine Medical Association.

Chairman Larson: Thank you very much, Dr. Foster, for this report. Are there any comments on this report? If not, we are now ready for the nomination of a Councilor from the Fifth District.

Dr. Thegen: Mr. Chairman, I nominate Dr. Harold S. Babcock as Councilor for the Fifth District.

This motion was duly seconded by several of the members present and was carried.

Dr. Stanwood: I hate to hold you up any longer but I should feel remiss in my duties as a delegate from Oxford County if I did not convey to the House of Delegates their wishes. What I have to say is with reference to pregnant wives of men in the service.

As most of you know, the State has assumed the financial responsibility to the extent of $35.00, and possibly many of you have received this sort of a letter. We, in Oxford County, felt that a post-script which is added here should be omitted. I shall read the letter, as it is not very long.

"Dear Mrs.

"Your application for maternity care service has been received and approved. We hope that you will go to your physician regularly for examination and advice during your pregnancy. The public health nurse in your territory has been notified of your care and she will be glad to tell you of the Child Health Conference available in your community, for the inspection and immunization of your child.

"If the baby needs medical care at any time during the first year of life, or if you wish consultation for yourself or baby, please communicate with your physician or the public health nurse and arrangements will be made when such care or help is needed.

"If you should change your place of residence before maternity is completed, kindly notify us if you wish to have your case transferred to a new location."

This letter is signed by Eleanor M. Blisch.

This is the post-script: "Patients are requested not to make any payment to the physician or the hospital for these services."

Now, we felt that that was an unwarranted reflection upon the medical profession. Many of these maternity patients have the means to pay, and we do not believe that the maximum should be $35.00, because before the case is completed it may amount to much more than that. But this post-script conveys the impression to the patient that the state assumes the full financial responsibility.

I am just bringing this thought to the House of Delegates from Oxford County.

Dr. Carswell: Mr. Chairman, I was instructed by my county society, likewise, on behalf of certain members who very strenuously objected, not merely to the inference conveyed by that letter, but also to the principle involved in dealing with that plan at all, to bring this matter before the House of Delegates, not through any lack of patriotism and not through a lack of desire to give to the wife of the serviceman all the care that she may need at a reasonable rate, but primarily on the basis of the fact that we believe that this is just another inroad, another tentacle reaching out to grasp us in a bold way to state medicine.

For that reason, we who are from Knox County would like to go on record—I should say some of us and I believe it is the majority of us—as opposing this plan. We realize that it is already a law. We realize that the Federal government is back of it, and the state is coöperating. But, at the same time, we feel that some protest should be made and put on record.

Dr. LeRoy Smith: This is just along the line that Dr. Mitchell and I were talking about this morning. If I were a Holy Roller, I would say, "Amen and Hallelujah!" to this. It is just a step towards state medicine, pure and simple. The more we acquiesce without protest, and perhaps even with protest, just the sooner are we going to be dictated to, as to which side of your head you're a going to comb your hair on, or what kind

of a tie you are going to wear. I had a little correspondence with Dr. Blisch. It came about this way. There are four or five expectant mothers, the wives of soldiers, who can only be taken care of at the Eastern Maine General Hospital in Bangor, or at the Waldo County Hospital in Belfast. Well, now, I don't do a lot of obstetric work, but I do some, and I deliver my patients in Bangor. But I also deliver them at a little maternity hospital in Winterport.

It is 28 miles getting up and back to Bangor, and I guess I am getting older or else I tire more easily or something, but fatigue seems to have set in on my shoulders rather firmly, and if I can save myself three hours or two hours by having a case in my immediate vicinity, which is a modern maternity home, conducted and supervised by a very competent nurse, a graduate of the Deaconess Hospital, it is much better for me. I will say that I have no interest in the place whatever, except as a time saver for myself. I get more sleep because my patients are there.

However, I am dictated to in this matter. And I am told, on the other hand, that they can be taken care of in their homes. Now, the little maternity home is far better than their homes. We won't say it is as good as the well-equipped hospital, but the mortality rate hasn't been very high, I am glad to say.

In a letter to Dr. Blisch, I pointed out the waste of time, the consumption of gasoline, tires, etc., but that didn't spin a thread. The Federal Government says thus-and-so, and it must be so. She brought out the fact that you must be where you could do blood transfusions. That kind of pleased me. I haven't done much obstetrical work, but I have done more or less during the past twenty-three years, and I have required just one transfusion; that was in a little old house in Winterport, when I got hold of one of my colleagues and had him get some blood for me.

Now, I should like to have this House of Delegates vigorously make a statement that we are opposed to too much dictation.

Dr. Johnson: This doesn't really involve me, but I am glad to hear the remarks of the three previous gentlemen. That is just the way we feel about the investigative work that is being done as far as venereal diseases are concerned.

I should like to quote something I read the other day, which can be exemplified by a new born baby.

"When you take a new born baby and you give him a good smack, if he struggles and keeps on struggling, he has a chance to survive; if he remains passive and refuses to struggle that is the beginning and the end."

Dr. Stanwood: Let us keep on struggling.

Dr. Smith: We won't be able even to make a surgical decision bye and bye.

Dr. Bliss: These things will come up for decision during the coming year, when the delegates are all home and we can't get an expression of opinion. But, discussing this law pro and con and exhibiting our disapproval of it does not repeal it. Exhibiting your disapproval of Federal regulations which have the force of law does not repeal them, and you go home with nothing accomplished. If some one wishes to make a proposal that we espouse civil disobedience, and that we refused to comply with this regulation and that law, here and now is the time in which to do it.

Chairman Larson: Are there any other comments? Is there any other new business to come before this meeting.

Dr. Zolov: This morning, Mr. Chairman, there was a very fine law passed by the organization, increasing the dues to $15.00. However, in my opinion, I do not think the dues were reasonably increased. Subsequent to the meeting this morning, I heard many a rumble among the members of the organization. I heard from some of the men the opinion that I had about the questions that would be asked of us when we get home. We are going to be asked why the dues are almost doubled.

Now, I understand that there is a considerable reserve in the Association, and I think that every organization should have a reserve. However, I feel, in my humble opinion, that the dues of the organization should be increased adequately to cover any losses that we may incur throughout the entire year. Therefore, I should like to go on record for a reconsideration of the law that was passed this morning, increasing the dues to $15.00.

Dr. Foster: Not voting for that increase, I think that it is my privilege to move to reconsider the matter, in order to bring it before the house again, if they so vote to reconsider it. I said something about meeting the expenses by either cutting down the budget or increasing the dues. The House decided not to decrease the budget; therefore, they felt it was necessary to increase the dues. But it seemed to a number of the men, as Dr. Zolov has said, that the increase is almost one hundred per cent; it is a large increase.

Through some consultation with the men, it was felt that the dues might be increased to $12.00 or $12.50.

Therefore, I move to reconsider the matter to raising the dues, making the dues $12.00 or $12.50.

This motion to reconsider was duly seconded by several of the members present and was carried.

Dr. Zolov: Mr. Chairman, I now move that the dues of the Maine Medical Association be increased to $12.00 a year.

Dr. Foster: On a point of information, Mr. Chairman. Does that mean that the dues to the State Association are to be $12.00 a year, and let the Counties tax on what they want to on top of that?

Dr. Zolov: Yes.

Dr. Foster: Then I will second the motion.

A Member: As a matter of discussion, it seems to me we might well decide, once and for a while anyway, whether that is going to bring us a requisite amount of money.

Chairman Larson (After conferring with Secretary Carter): Under the present membership, it is not quite adequate to meet the present budget, but the likelihood is that the present budget as promulgated this morning will not be entirely spent. I think that perhaps the $12.00 will cover the expenses for the coming year.

Dr. Kershner: But it won't replace the deficit for last year.

A Member: I understand that is for the duration of the war.

Dr. Foster: The Constitution and By-Laws provide that the dues may be changed at the House of Delegates' meeting at any meeting. I think that it has to go from year to year.

Dr. Kershner: Than it has to be brought up every year?

Chairman Larson: Of course, if we had the dues $12.00 this year and it wasn't quite adequate, we could make it higher for next year.

There is a motion before the House that the dues be raised to $12.00. All those in favor will manifest by raising the hand.

The majority of hands were raised, and the motion was carried.

Chairman Larson: Is there any further business to come before the meeting?

If not, I now declare this Second Meeting of the House of Delegates adjourned.

(Whereupon, the meeting was adjourned at six o'clock in the afternoon.)

Index

VOLUME THIRTY-FOUR

THE JOURNAL

of the

MAINE MEDICAL ASSOCIATION

Officers of the Maine Medical Association

1943-1944

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Third District,	Knox, Lincoln, Sagadahoc	C. Harold Jameson, M. D., Rockland,	1944
Fourth District,	Kennebec, Somerset, Waldo	John O. Piper, M. D., Waterville,	1944
Fifth District,	Hancock, Washington	Harold S. Babcock, M. D., Castine,	1946
Sixth District,	Aroostook, Penobscot, Piscataquis	Forrest B. Ames, M. D., Bangor,	1946

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INDEX

Volume Thirty-four

Guide

January	Number One	Pages 1- 23	July	Number Seven	Pages 129-146
February	Number Two	Pages 25- 43	August	Number Eight	Pages 147-168
March	Number Three	Pages 45- 61	September	Number Nine	Pages 169-188
April	Number Four	Pages 63- 80	October	Number Ten	Pages 189-208
May	Number Five	Pages 81-101	November	Number Eleven	Pages 209-229
June	Number Six	Pages 103-127	December	Number Twelve	Pages 231-252

Articles

B

PAGE

Blood:
Rh Factor, Significance of (Porter, Joseph E.) 63
Burns:
Treatment (Brinkman, Harry) 1

C

Cancer Clinics:
Eligibility of Patients for Services (Warren, Mortimer; Ames, Forrest B.; Kobes, Herbert R.) 51
Civilian Medical Defense:
Emergency Medical Service (Reggio, A. William) 147

H

History:
Charitable Dispensary and Tuberculosis Class of Portland (Burrage, Thomas J.) 174
Medieval Guilds of Medicine (Karsner, Howard T.) 103
Hospital Care:
Department of Health and Welfare Problem (Kobes, Herbert R.) 131

M

Medical Practice and Licensure, Difficulties of (Leighton, Adam P.) 231
Medicine:
Doctor of — His Responsibility (Adson, Alfred W.) 66
Meningitis:
Epidemic — Cerebrospinal and Spotted Fever (Mitchell, Roscoe L.) 45
Meningococcus (Martin, Ralf) 49
Pfeiffer Bacillus (Steele, Charles W.) 212
Mental:
Dementia Praecox (Tyson, Forrest C.) 151
Freudian Theories — History and Criticism (Newman, Israel) 4
Neuro-Psychiatric Casualties at a Naval Hospital (Stearns, A. Warren; Schwab, Robert S.) 81
Myasthenia Gravis (Geyerhahn, George) 209

P

Presidential Address:
Carl H. Stevens, M. D., Belfast, President, Maine Medical Association, 1942-43 129

S

Sulfonamides:
Sulfa Drugs in Traumatic Surgery (Winchenbach, Francis) 90

T

Tuberculosis:
Out-Patient Department in Control of (Daniels, David) 29
State Responsibility for Control of (Pope, Alton S.) 25
Tumors:
Cerebellar Astrocytoma (Pratt, T. Dennie; McQuillan, A. H.) 189

PAGE

V

Vascular Diseases:
Peripheral, Treatment by Interruption of the Sympathetics (Harvey, Samuel C.) 169

W

Wagner-Murray-Dingell Social Security Act:
Discussion of Section XI, Title IX (Eustis, A. G.) 236

Authors

Adson, Alfred W., Rochester, Minnesota 66
Ames, Forrest B., Bangor, Maine 51
Brinkman, Harry, Farmington, Maine 1
Burrage, Thomas J., Portland, Maine 174
Daniels, David, Greenwood Mountain, Maine 29
Eustis, A. G., Waterville, Maine 236
Geyerhahn, George, South Portland, Maine 209
Harvey, Samuel C., New Haven, Connecticut 169
Karsner, Howard T., Cleveland, Ohio 103
Kobes, Herbert R., Augusta, Maine 131-51
Leighton, Adam P., Portland, Maine 231
Martin, Ralf, Portland, Maine 49
McQuillan, A. H., Waterville, Maine 189
Mitchell, Roscoe L., Augusta, Maine 45
Newman, Israel, Augusta, Maine 4
Pope, Alton S., Boston, Massachusetts 25
Porter, Joseph E., Portland, Maine 63
Pratt, T. Dennie, Waterville, Maine 189
Reggio, A. William, Boston, Massachusetts 147
Schwab, Robert S., Boston, Massachusetts 81
Stearns, A. Warren, Boston, Massachusetts 81
Steele, Charles W., Lewiston, Maine 212
Stevens, Carl H., Belfast, Maine 129
Tyson, Forrest C., Augusta, Maine 151
Warren, Mortimer, Portland, Maine 51
Winchenbach, Francis, Bath, Maine 90

Editorials

A

American Physicians Dead in Military Service in 1942 37
Army's 1943 Recruiting Program Will Require 6,900 Physicians 70
Armed Forces Must Have 6,000 More Physicians by January 178

C

Council—Maine Medical Association:
Votes in Favor 1944 Annual Session 155
Council and Scientific Committee Meet 222

I

Invalid Diets and Food Rationing 71

H

House of Delegates—Maine Medical Association:
House of Delegates, 1943 107
Highlights of 1943 Meeting 139
Proceedings of 1943 Meeting 155

M

Maine Physicians and the War Program 53
Medical and Public Opinion Against Health Bill 197
Membership, Maine Medical Association, Status of 36

P

Penicillin Research, First Clinical Report 241
Physicians Must Volunteer from Larger Cities 91
Physicians Needed as Replacements in Civilian Service 36
Procurement and Assignment Service:
Roland L. McKay, M. D., Named State Chairman 53

W

War Problems to be Discussed by Industrial Health Congress 13
Why Another Bureaucracy 222

General

A

American Medical Association:
Council on Medical Service and Public Relations, Purposes and Functioning of 243
Platform of 10
Abstract:
From "Delay in Treatment of Cancer" 48

B

Book Reviews:
Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association, 1941 61
Arthritis in Modern Medicine (Otto Steinbrocker, M. D.) 21
A Manual of Pharmacology and Its Application to Therapeutics and Toxicology (Torald Sollman, M. D.) 101

PAGE

A Primer on the Prevention of Deformity in Childhood (Richard B. Rancy, M. D.—Alfred Rives Shands, Jr., M. D. 22
A Textbook of Clinical Neurology (Israel S. Wechsler, M. D.) 163
A Textbook of Surgery (Edited by Frederick Christopher, M. D.) 61
Blood Grouping Technic (Fritz Schiff, M. D.—William C. Boyd, Ph. D.) 162
Communicable Disease Nursing (Theresa I. Lynch, R. N.) 41
Directory of Medical Specialists Certified by American Boards, 1942 61
Diseases of Metabolism — Detailed Methods of Diagnosis and Treatment (Garfield G. Duncan, M. D.) 22
Encephalitis — A Clinical Study (Josephine B. Neal, M. D.) 22
Infant Nutrition (William McKim Marriott, M. D.—Revised by P. C. Jeans, M. D.) 162
Management of the Sick Infant and Child (Langley Porter, M. D. — William E. Carter, M. D.) 42
Mental Illness—A Guide for the Family (Edith M. Stern—Samuel W. Hamilton, M. D.) 163
Military Medical Manuals—Dermatology 41
Military Surgical Manuals, Vol. VI—Neurosurgery and Thoracic Surgery 163
Nephritis (Leopold Lichtwitz, M. D.) 60
New and Non-Official Remedies—1942 (Council on Pharmacy and Chemistry, A. M. A.) 60
Occupational Diseases (Rutherford T. Johnstone, M. D.) 101
Physicians Reference Book of Emergency Medical Service (E. R. Squibb & Sons) 42
Professional Adjustment — I (Gene Harrison, R. N.) 23
Reports of the Council on Pharmacy and Chemistry—American Medical Association 163
Shock Therapy in Psychiatry (Lucie Jessner, M. D.—V. Gerard Ryan, M. D.) 23
Surgery of the Ambulatory Patient (L. Kraeer Fersuron, M. D.—Louis Kaplan, M. D.) 41
Surgical Practice of the Lahey Clinic, Boston, Massachusetts 21
Synopsis of Allergy (Harry L. Alexander, M. D.) 21
Synopsis of Ano-Rectal Diseases (Louis J. Hirschman, M. D.) 162
Synopsis of Genitourinary Diseases (Austin I. Dodson, M. D.) 23
Synopsis of Materia Medica, Toxicology, and Pharmacology (Forrest Ramon Davison, M. D.) 101
Synopsis of the Preparation and Aftercare of Surgical Patients (Hugh C. Illgenfritz, M. D. —Rawley M. Penick, Jr., M. D.) 23
The Art and Science of Nutrition (Estelle E. Hawley, Ph. D.—Grace Carden, B. S.) 23
The Blood Bank and the Technique and Therapeutics and Transfusions (Robert A. Kilduffe, M. D.—Michael De Bakey, M. D.) 22
The Conquest of Bacteria—From Salvarsan to Sulphapyridine (F. Sherwood Taylor) 163
The Eye Manifestations of Internal Diseases (I. S. Tassmann, M. D.) 60
The March of Medicine—New York Academy of Medicine 21-162
The Modern Attack on Tuberculosis (Henry D. Chadwick, M. D.—Alton S. Pope, M. D.) 42
The Principles and Practice of Obstetrics (Joseph B. DeLee, M. D. — J. P. Greenhill, M. D.) 162
The Toxemias of Pregnancy (William J. Dieckmann, M. D.) 21
Treatment in General Practice (Harry Beckman, M. D.) 61
Woman's Personal Hygiene — Modern Methods and Appliances (Leona W. Chalmers) 22

C

Civilian Medical Defense:
New Recommendations on Burns and Wound Infections in Air Raid Casualties 158
County Medical Societies:
Members in Military Service 19-40-59-80-98-111-121-161
New Members 40-58-80-98-111-144-161-228-246
News and Notes:
Androscoggin 58
Aroostook 160-245
Cumberland 97-144
Franklin 58
Hancock 79
Kennebec 18-98-227
Knox 39-205
Lincoln-Sagadahoc 110
Oxford 160-205
Penobscot 18-39-79-98-110-144-246
Piscataquis 18-144-206-246

PAGE
Somerset 98
Waldo .....
Washington 79-110-161-227
York 40-98

E
Excerpt from "The Role of the Cancer Clinic in Cancer Control" 238

H
Hospital Notes:
Maine General Hospital, Maternity Care 100

K
Kerato-Conjunctivitis Epidemic—Special Warning Bulletin 76

L
Legislation—1943 Maine Legislature:
Legislation of Interest to Physicians, Report of Herbert E. Locke, Esq., Counsel, Maine Medical Association 96
Infectious and Communicable Disease Law:
Correspondence—Herbert E. Locke, Esq. 94
Correspondence—Leroy R. Folsom, Assistant Attorney General 181
Public Laws, 1943, Chapter 358—An Act Relating to Infectious and Communicable Diseases 95
Report of Social Hygiene Committee 180
Pre-marital Medical Examination, An Act Relating to, Correspondence 146

M
Maine Board of Registration of Medicine 19-100-161
Maine Medical Association:
Budget, 1943-44 164
Committees, 1943-44:
Special 141
Standing 140
Committee Reports, 1942-43:
Special Committees:
Graduate Education 116
Industrial Health 116
Investigate Collection Agencies 116
Maternal and Child Welfare 116
Standing Committees:
Cancer 115
Legislative 115
Medical Education and Hospitals 114
Public Relations 115
Council Reports:
First District (E. Eugene Holt) 113
Second District (Currier C. Weymouth) 113
Third District (C. Harold Jameson) 113
Fourth District (John O. Piper) 113
Fifth District (Oscar F. Larson) 114
Sixth District (Norman H. Nickerson) 114
Delegate's Report:
American Medical Association, 1943 (Thomas A. Foster, M. D.) 166
House of Delegates, 1943:
County Delegates 120
Officers Elected 138
Order of Business 99-119
Proceedings—First Meeting 164
Proceedings—Second Meeting 185
Necrologist Report "In Memoriam" 112

PAGE
President, 1943-44, Oscar F. Larson, M. D., Machias 135-136
President's Page, Oscar F. Larson, M. D. 137-154-177-196-221-239
Roster, Maine Medical Association: (May 31, 1943)
Members in Military Service 121
Members and Honorary Members 123
Secretary's Report 117
Treasurer's Report 117
Maine Public Health Association:
The Early Diagnosis Campaign for the Prevention of Tuberculosis 74
Maternal and Child Welfare: (Articles submitted by Committee on Maternal and Child Welfare)
Abortion 72
Anorexia in Children 156
Breast Feeding 54
Correction 225
Feeding in the First Year 108
Formulae 179
Immunizations and Specific Therapy in Common Contagious Diseases 92
Indigestion in Infancy 142
Pediatric Therapeutics 202
The Newborn 14-37
Medical and Hospital Care for Wives and Infants of Men in Military Service 11
Medico-Legal Society of Maine:
Annual Meeting, 1943 145
Program 111

N
National Conference—Planning for War and Post War Medical Services, Report of Delegate, Thomas A. Foster, M. D. 71
Notices 19-59-80-100-145-161-183-206-246

P
Procurement and Assignment Service:
Attention, Please! 14

W
Wagner-Murray-Dingell Bill:
Analysis by Bureau of Legal Medicine and Legislation of the American Medical Association 199
Open Letter (New England Medical Societies) .. 240
Wartime Nursing is Different 194

Necrologies

Abbott, Edward Sewall, Bridgton (1863-1943) 226
Bean, Johnson L., Norway (1905-1943) 182
Blake, James P., Harrison (1865-1942) 17
Currier, Everett B., Phillips (1866-1943) 143
Freeman, Fred H., Gardiner (1878-1943) 78
Garcelon, Harold Webb, Auburn (1883-1943) 112
Marsh, Ralph Hemenway, Guilford (1863-1942) 17
Miller, George F., Belfast (1876-1943) 78
Milliken, Herbert Eldridge, Portland (1880-1943) 57
Mitchell, Alfred, Jr., Portland (1872-1943) 57
Mitchell, Frederick W., Houlton (1873-1943) 204
Nutting, James Deering, Hallowell (1875-1943) 226
Phillips, Robert Titus, Portland (1901-1943) 143
Smith, Harry W., Norridgewock (1870-1943) 182-204
Smith, Owen, Portland (1869-1943) 182
Williams, Adelbert Franklin, Phippsburg (1870-1943) 78